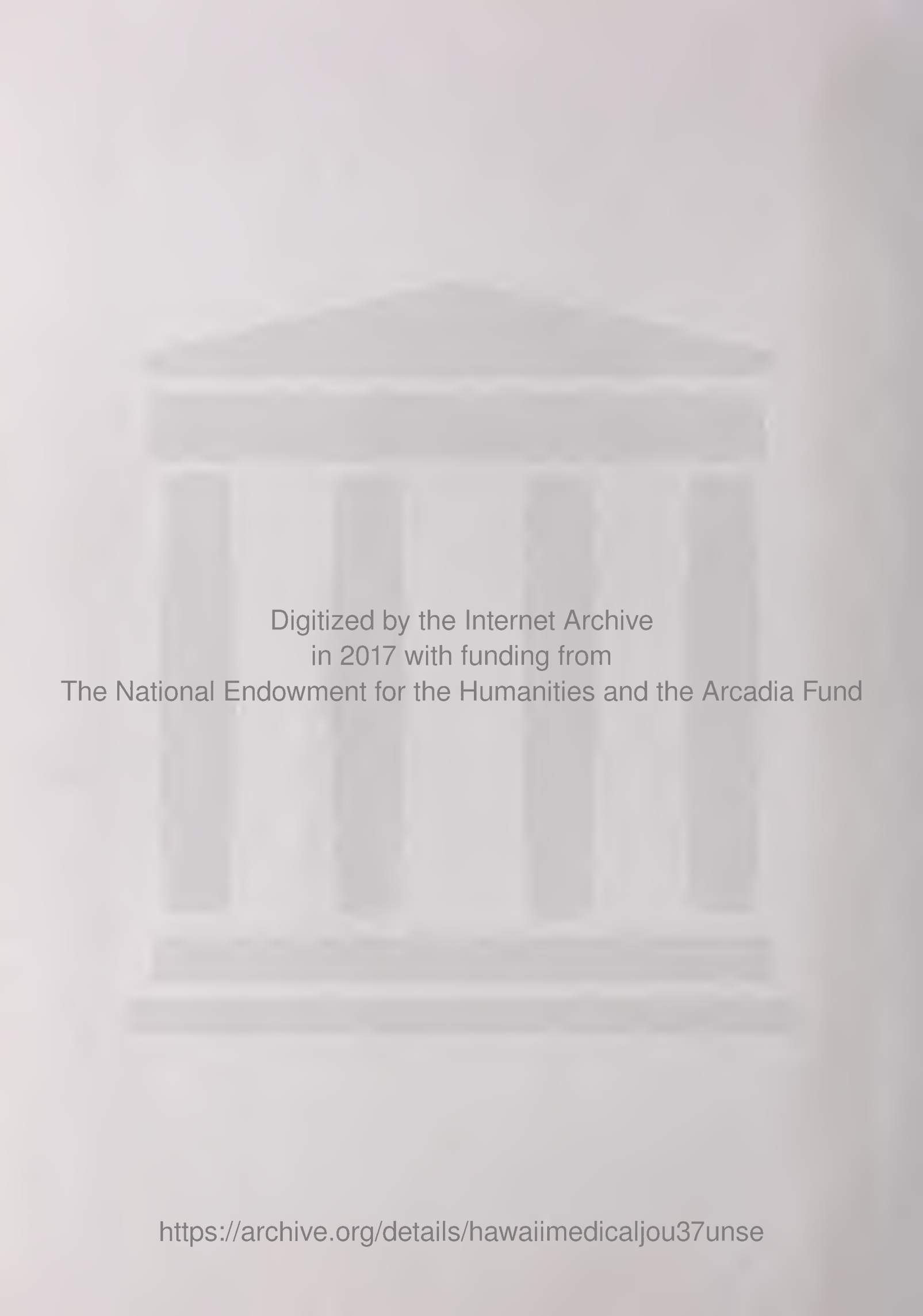

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JANUARY, 1978
VOL. 37, NO. 1

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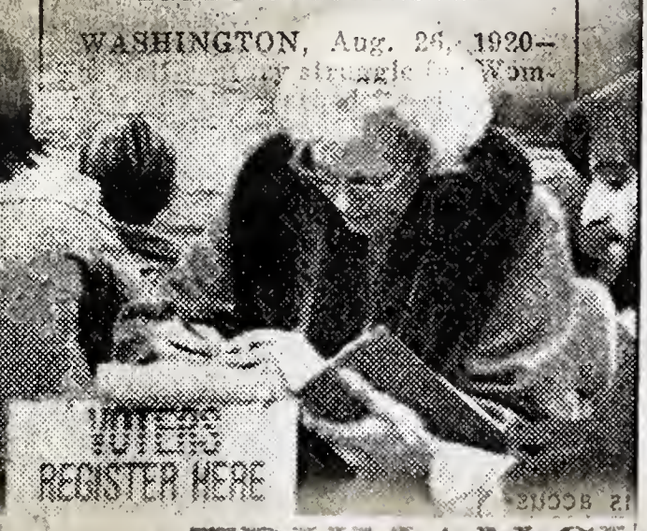
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WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,0 Persons When States Adopt Cooperating Laws–He the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14 The Social Security Bill, p a broad program of unemp insurance and old age p and counted upon to bene 20,000,000 persons, became day when it was signed b dent Roosevelt in the pres those chiefly responsible t ting it through Con

Mr. Roosevelt cal "the cornerstone whi is being me s comple ri to

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

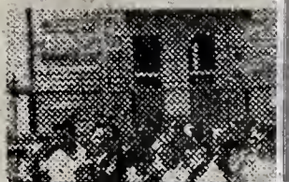
The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGNI the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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Warnings: *Drug dependence.* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration, prescribe and administer with same caution appropriate to other oral narcotics. Subject to the Federal Controlled Substances Act. *Usage in ambulatory patients:* Caution patients that codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery. *Interaction with other CNS depressants:* Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) with this drug may exhibit additive CNS depression. When such a combination is contemplated, reduce the dose of one or both agents. *Usage in pregnancy:* Safe use not established. Should not be used in pregnant women unless potential benefits outweigh possible hazards.
Precautions: *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. *Acute abdominal conditions:* Codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions. *Special-risk patients:* Administer with caution to certain patients such as the elderly or debilitated and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.
Adverse Reactions: Most frequent: lightheadedness, dizziness, sedation, nausea and vomiting, more prominent in ambulatory than nonambulatory patients, some of these reactions may be alleviated if the patient lies down. Others: euphoria, dysphoria, constipation and pruritus.
Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.
Full directions for use should be read before administering or prescribing.
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Jejuno-Ileal Bypass for Morbid Exogenous Obesity

JOHN F. BALFOUR, M.D., *Honolulu*

"Lament of an Unsuccessful Weight Watcher"[1]

My intertriginosity
Is caused by adiposity;
I wonder where the increment will end?
Such fleshly generosity
Impedes my true velocity
And also makes it difficult to bend.
I have no curiosity
To be a great monstrosity–
Such wishfulness I cannot comprehend;
In fact, this corporosity
Fills me with animosity,
Because I can't reverse the "growing" trend!

At present, contrary to conditions that exist in less fortunate areas of the world, obesity is the principal nutritional disease in the United States.[2]

It has been estimated that more than half the population over the age of 40 in the U.S. suffers from obesity. Some physicians argue that when such a high proportion of the population is in such a state, many in the group should be considered normal. However, excess weight can be damaging in several ways. When it persists it is associated with significantly increased mortality and morbidity, particularly due to cardiac, vascular, and renal disorders. Indeed, obesity is not simply a disease in itself, but a harbinger of other diseases as well. Fat people are more prone to diabetes, fatty liver, cirrhosis of the liver, alcoholism, biliary calcinosis, atherosclerosis, coronary occlusion, heart failure, nephrosclerosis, and hypertension.

Fig. 1 compares death rates of obese to standard risk individuals, analyzed as to cause of death.

There is a distinct increase in mortality with increasing degrees of obesity. In men, mortality rates are increased 13% for those 10% overweight, 25% for those 20% overweight, and 40% for those 30% overweight.[3]

FIG. 1.—*Ratio of death rate of obese to standard risk individuals analyzed as to cause of death (Barr)*

CONDITION	MEN	WOMEN
Diabetes	3.83	3.72
Cirrhosis of liver	2.49	1.47
Appendicitis	2.23	1.95
Biliary calculi	2.06	2.84
Chronic nephritis	1.91	2.12
Cerebral hemorrhage	1.59	1.62
Coronary disease	1.42	1.75
Auto accidents	1.31	1.20
Suicides	0.78	0.73
Tuberculosis	0.21	0.35

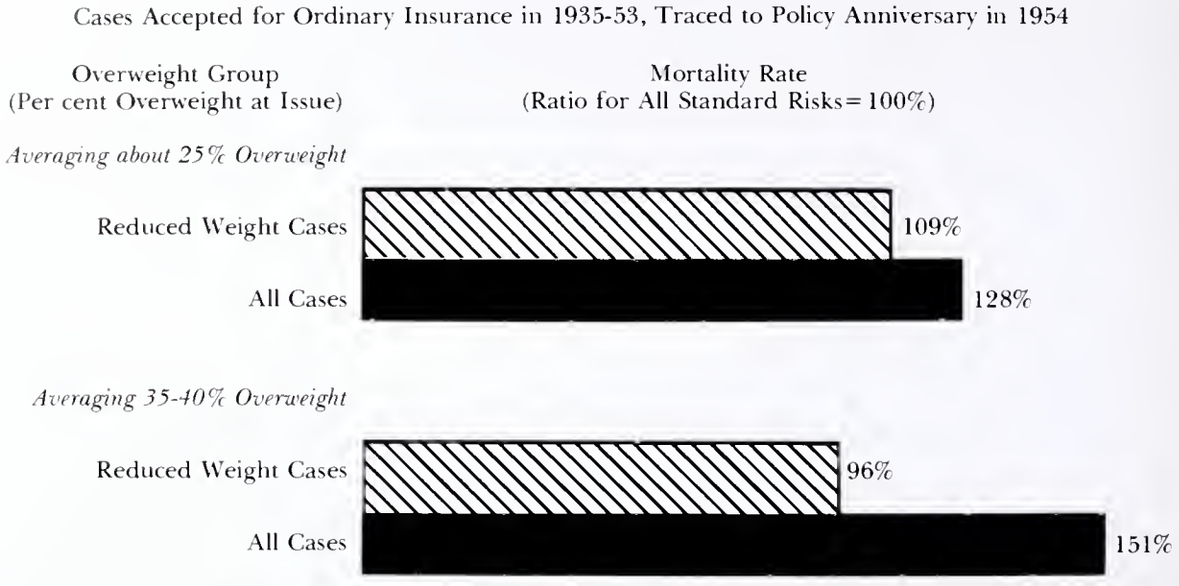
As shown by insurance actuarial tables, significant weight reduction can favorably influence this mortality ratio (Fig. 2). However, efforts to reduce weight in the very obese have been abysmally unsuccessful.[4] Stunkard and McLaren-Hume from the Medicine and Psychiatric Departments of New York Hospital reviewed the literature and reported on a series of 100 consecutive obese patients treated in their nutrition clinic. Their review of the literature covered reports from the last thirty years. Although people reported on were grossly overweight, only 25% were able to lose 20 pounds and only 5% lost 40 pounds. The success rate from their own nutrition clinic was even more dismal. Only 12% were able to lose 20 pounds, and only one patient lost 40 pounds. Two years after the end of treatment, only two patients had maintained their weight loss!

Clinical Study

Criteria for selection of patients with massive obesity as candidates for extensive jejuno-ileal bypass have continued essentially the same as those used by Payne and Scott.[5] These are as follows: 1) Obesity of massive degree (weights 2-3 times ideal levels, of at least five years' duration). 2) Evidence from attending physician indicating failure of dietary efforts to correct obesity over a period of years. 3) Evidence from patient's his-

Accepted January, 1977.

FIG. 2.—*Mortality of overweight men subsequent to weight reduction and of all overweight men*



tory and evaluation indicating patient's apparent inability to adhere to prescribed dietary regimens or exercise programs. 4) Absence of any correctible endocrinopathy (such as hypothyroidism or Cushing's syndrome) which might be the cause of obesity. 5) Absence of any other unrelated significant disease which might increase operative risk. 6) Presence of certain complications such as Pickwickian syndrome, hyperlipidemia, adult onset diabetes, or hypertension, which might be alleviated by significant weight reduction with intestinal bypass. 7) Assurance of patient's cooperation in conduct of pre- and post-operative metabolic and body compositional studies and prolonged followup evaluation.

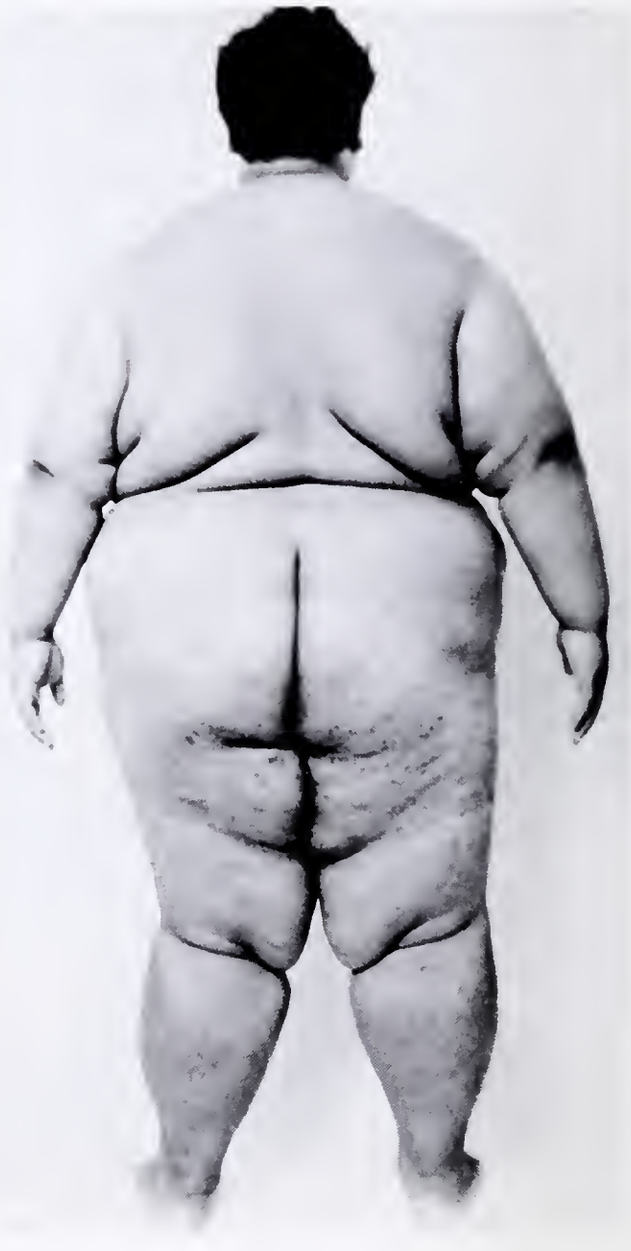
Eleven patients are included in this study, 5 men and 6 women, ranging in age from 16 to 42 years. Fig. 3 shows the habitus of a typical patient immediately prior to operation. The preoperative weight for all 11 patients averaged 232% of ideal (Metropolitan Life Insurance Tables, 1959),[6] with a range of 205 to 294%. The average height of the patients in the series was 5′5″, the average weight being 315 pounds.

In all patients, various dietary and pharmacological methods designed to effect weight reduction and control obesity had been ineffective. Psychotherapy and hypnosis had been tried in 2 without significant success.

Baseline studies were carried out, with special attention toward detecting possible endocrine causes of obesity. Evaluation of cardiopulmonary status, baseline absorptive and metabolic studies, and psychiatric evaluation was also performed.

Endocrine studies included evaluation of thyroid function by determination of T4 normalized, and Achilles' tendon reflex time. Studies of adrenal function included A.M. and P.M. plasma cortisol determinations as well as 24-hour urine collections for measurement of 17-hydrocorticosteroids and 17-ketosteroids. Skull x-rays were obtained. Pulmonary studies

FIG. 3.—*Habitus of typical patient prior to operation*



included measurement of arterial PO2, PCO2, and pH in addition to determination of forced expiratory vital capacity, one second % of FEVC, maximum mid-expiratory flow rate, expiratory reserve, inspiratory capacity, and maximal breathing capacity. Cardiovascular appraisal included roentgenograms of the chest, EKG's, determination of serum lipids including cholesterol, triglycerides, and lipoprotein electrophoretic patterns.

Extensive dietary histories were taken. In addition, gastroenterologic studies included upper GI series and cholecystograms. Gastric analysis measuring maximum acid output and peak acid output in mEq/hour, as well as serum gastrin levels, were obtained. Intestinal absorption was evaluated by glucose tolerance tests, cobalt-60 vitamin B-12 absorption tests (Schilling), and serum carotene levels. Preoperative measurements of serum calcium, potassium, magnesium, and other electrolytes, as well as vitamins A, B-12, and folic acid were made.

Psychologic evaluation of each patient involved the use of standard psychological tests, including the MMPI, as well as interviews with staff psychologists or psychiatrists when deemed advisable.

Operative Procedure

The initial patient in the series was treated with a jejuno-ileal bypass as described by Payne and DeWind,[7] anastamosing the proximal 14 inches of jejunum to the distal 4 inches of ileum in an end-to-side manner. The proximal end of the defunctionalized small intestine was closed with a TA-30 stapler and anchored to the root of the small bowel mesentery to prevent intussusception.

The other patients in the series were treated with an end-to-end jejuno-ileal bypass as described by Scott, et al.[8] The lengths of functional small bowel included 12 inches of jejunum beyond the ligament of Treitz to varying lengths of terminal ileum, ranging from 12 inches to 7 inches.[9] All measurements were taken on the mesenteric border with the bowel placed on a stretch. The proximal end of the defunctionalized small bowel was closed with a TA-30 stapler and anchored to the root of the small bowel mesentery, while the distal end was anastomosed end-to-side to the right transverse colon. Liver biopsies and appendectomies were routinely performed. Additional procedures included a cholecystectomy in one patient.

Results

Preoperative clinical evaluation of the 11 patients showed a variety of abnormalities in addition to massive obesity. Family history of significant obesity was elicited in 4 of the 11 patients. One patient had symptomatic gallstones.

One patient had glycosuria and diabetic glucose tolerance tests. Her fasting and 3-hour serum insulin levels were actually elevated. However, 6 patients had flattened glucose tolerance curves with some degree of hyperinsulinemia. Endocrine studies were otherwise normal in all of the patients.

In 6 of the 11 patients there was a significant restrictive ventilatory defect as measured by forced expiratory vital capacity (FEVC) preoperatively. This finding was compatible with reduced chest wall compliance secondary to obesity.

Cardiac evaluation before operation showed increase in the diastolic pressures in the range of 100-110 in 4 of the 11 patients. Chest x-rays and EKG's were normal in all patients. Two patients had elevated cholesterols and abnormal lipoprotein electrophoretic patterns indicating Fredrickson Type II hyperlipoproteinemia. Serum triglycerides were elevated in 4 patients, one of whom had a lipoprotein pattern indicating Fredrickson Type IV.

Serum vitamin levels, electrolytes, and hemotologic function prior to surgery showed no significant abnormalities. Upper GI series revealed a sliding hiatus hernia in one patient.

Three patients suffered from significant low back pain and one experienced intermittent sciatica. One patient had a postphlebitic lower extremity with a marked amount of edema, stasis dermatitis, and a chronic leg ulcer. A fair and varied amount of neuroses were indicated by the MMPI, but there were no psychoses.

Liver biopsies were obtained in 10 of the 11 obese patients. Abnormal accumulations of fat ranging from a minimum to severe degree was present in all patients.

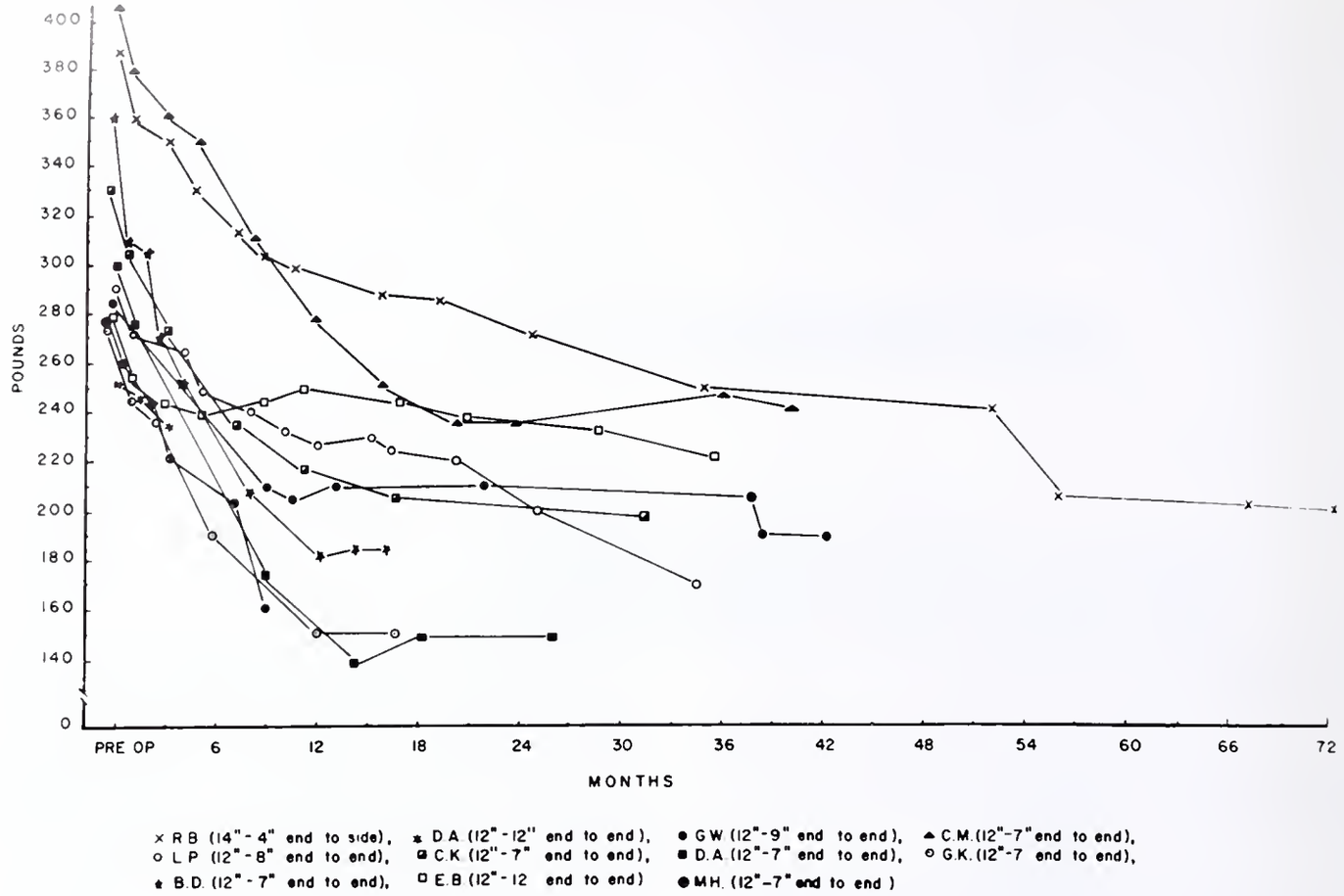
Postoperative complications included massive upper GI bleeding, occurring a few days after bypass, in the patient with the hiatus hernia. The hemorrhage was secondary to a Mallory-Weis tear at the cardio-esophageal junction induced by violent retching. The bleeding was stopped and a hiatus hernia repair was performed through a thoracotomy incision.

One patient developed pulmonary emboli which responded to anticoagulation and has suffered no sequelae. Frank wound infections developed in 2 patients requiring wide opening of the skin and fatty layers of the wound down to the fasia.

One patient developed a left ureteral calculus 3 months after surgery which required hospitalization for a few days. The stone passed spontaneously.

The chronology of weight loss after jejuno-ileal bypass is illustrated in graphic form in Fig. 4. After the precipitous weight loss induced by the operative procedure and its catabolic effects in the immediate post-operative period, a majority of patients have lost weight on a gradual and steady basis during the period of followup. Weight loss in the 2 patients receiving a 12-12 inch bypass (D.A. and E.B.) has been unsatisfac-

FIG. 4.—*Chronology of weight loss after bypass*



tory, being only 20 and 50 pounds after stabilization. One patient (G.W.) received a 12-9 inch bypass, and he has now stabilized at 187 pounds, having lost 94 pounds. Another patient (L.P.), with a 12-8 inch bypass, lost 94 pounds in 26 months. The one patient in whom a 14-4 inch end-to-side bypass was performed (R.B.) is now stable at 201 pounds more than 6 years post-surgery, after having lost 186 pounds. The other 6 patients have 12-7 inch bypasses and are losing very significant amounts of weight, well over 100 pounds in the first year, with 4 of them stabilized after having lost an average of 161 pounds apiece.

Two patients (E.B. and L.P.), not being satisfied with their weight loss after stabilization, have recently lost additional weight, 10 and 27 pounds respectively, by restriction of their caloric intake.

No patient in the group has required regular medication for control of diarrhea after 6 months. In the majority of the group, diarrhea had ceased to be a problem after 4-6 months, and medication for its control has not been required. After weight stabilization at 1 to 2½ years, patients have 1 to 4 formed to semi-formed stools a day, unless they indulge in excessive liquid or fat intake. All patients have returned to the occupations of the preoperative period and unrestricted activity.

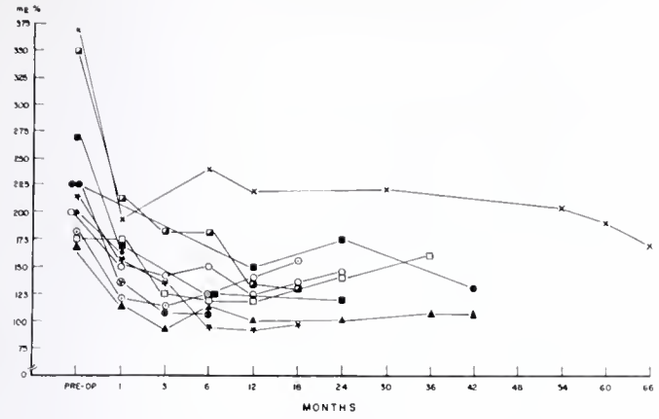
Metabolic parameters which were assessed prior to operation have been studied in the period of followup. Reduction in carbohydrate absorption as indicated by further flattening of the oral glucose tolerance curves in the post-operative period has been observed in patients in whom this has been measured. The one patient with a diabetic glucose tolerance curve and glycosuria preoperatively developed a flattened glucose tolerance curve and did not manifest any glucosuria in the postoperative period. Her serum insulin levels were normal when measured 2 years after surgery.

A large increase in fecal fat loss has occurred in these patients. There has been an impressive and sustained fall in serum cholesterol irrespective of baseline studies. In Fig. 5, serum cholesterol is plotted against time. Overall, there has been a 41% fall postoperatively. Serum triglycerides have dropped to normal levels in 2 of 4 patients in whom they were elevated preoperatively.

After jejuno-ileal bypass, lipoprotein electrophoresis patterns have reverted to normal in the 2 patients with Fredrickson Type II curves and have shown no change in the patient with Type IV disease. Serum carotenes have been subnormal at 6 months, returning towards normal levels by 1½ years. Prothrombin times have not been depressed, indicating adequate absorption of vitamin K.

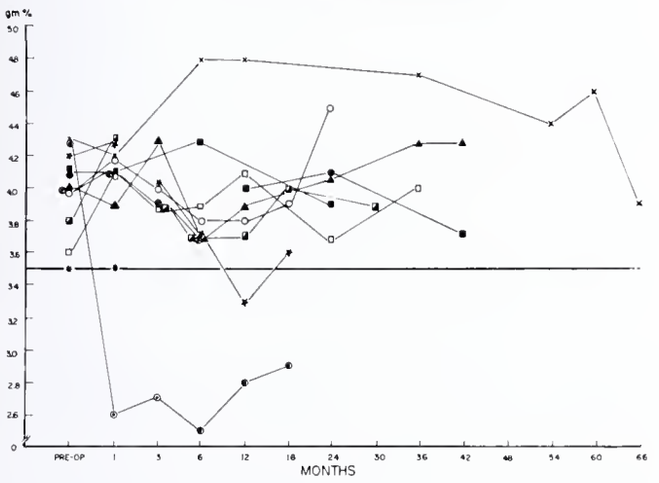
Serum levels of vitamin A, B12, and folate have remained in normal range. Hematocrits and hemoglobins have remained in normal range. Despite the diarrhea induced by the operation, serum, calcium, magnesium, and potas-

FIG. 5.—*Total serum cholesterol*



sium levels have remained normal during the period of followup. However, supplemental oral potassium was required up to a year in a few patients. Total serum proteins have been well maintained. Hypoalbuminemia has been observed in just one individual (G.K.) Fig. 6, but is now near normal levels 1½ years after surgery.

FIG. 6.—*Total serum albumin*



The serum uric acid data, Fig. 7, reflect a trend toward hyperuricemia in a few of these massively obese patients. Except for early postoperative elevations, the levels show little change from the baseline throughout the followup periods.

FIG. 7.—*Serum uric acid*

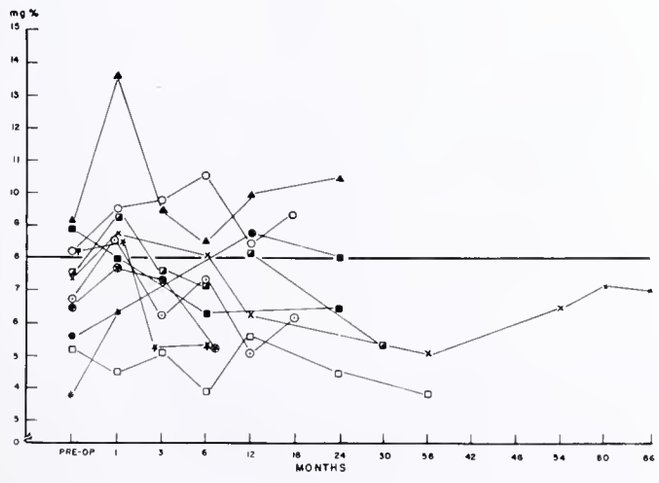


FIG. 8.—*Total serum bilirubin*

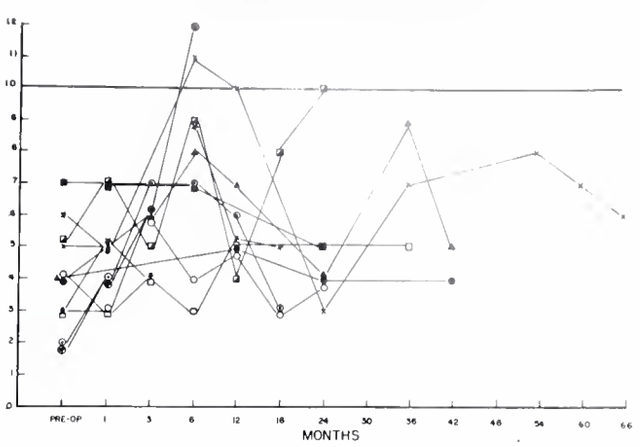


FIG 9.—*Serum alkaline phosphatase*

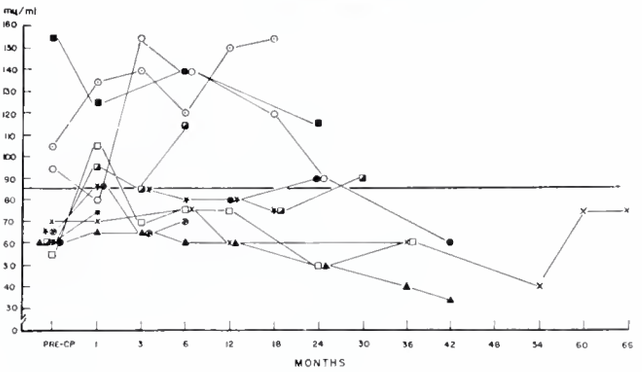


FIG. 10.—*L.D.H. levels*

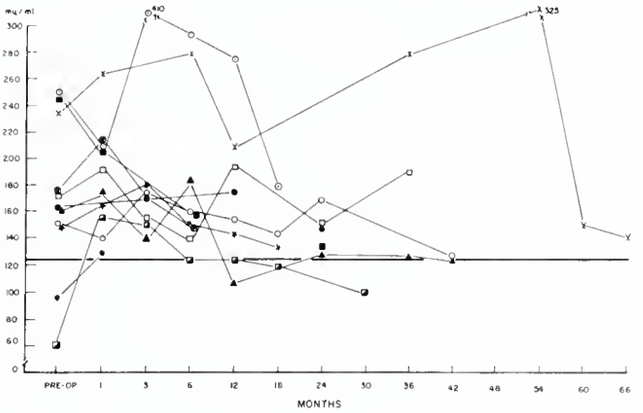
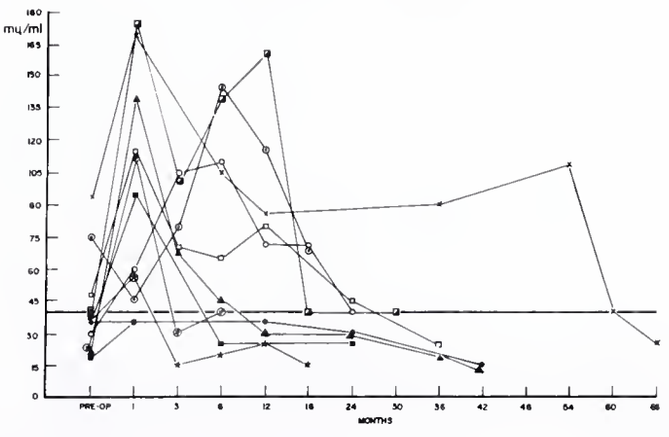


FIG. 11.—*S.G.O.T. levels*



Bilirubin (Fig. 8) has remained normal in 10 patients, being slightly elevated at 1.2 mg% in the most recent patient at 6 months. Alkaline phosphatase (Fig. 9) tends to rise initially in some patients, returning toward preoperative levels after a year. LDH (Fig. 10) has returned to normal in all patients. SGOT levels (Fig. 11) tend to return to preoperative levels after initial elevation.

Pulmonary function tests returned to normal in 3 of 6 patients in whom they were abnormal preoperatively, with an additional 2 patients showing significant improvement when measured 1½ years after surgery.

The 4 hypertensive patients all became normotensive a year to 2 years after surgery. The 3 patients suffering from low back pain all experienced significant improvement in their symptoms postoperatively. Sciatica is no longer a problem in the patient who had been bothered with that symptom.

Stasis dermatitis and ulceration in a postphlebitic lower extremity improved rapidly with weight loss. The ulcer has gone on to complete healing.

No significant postoperative psychiatric problems were encountered, except for some depression and disappointment in patient DA, who failed to achieve satisfactory weight loss. The other patients were grateful for the procedures and pleased with the results.

Summary

The use of jejuno-ileal shunt should be considered an investigative procedure, with the patients so informed. It should be considered only in rare cases where less radical measures have failed to produce results in patients whose obese state has become a hazard to health. The patients are committed to a long-term careful followup.

Unfortunately, the use of bypass procedures initially and rightfully received a bad name due to the complications encountered. These initial procedures were primarily jejuno-colic shunts. An inordinate number of postoperative problems arose, such as excessive diarrhea, occasional liver failure, and excessive fluid and electrolyte losses. The latter were primarily manifested by deficits in potassium, calcium, and magnesium. Occasionally, high protein diets were necessary to maintain normal serum albumin levels. In addition, vitamin B12 had to be administered on a routine basis postoperatively. An unacceptably high number of shunts had to be taken down and reanastomosed because of inability to handle the complications or because of patient requests. Universally, weight was regained to preoperative levels after restoring the intestinal continuity.

The use of the more recent jejuno-ileal shunts as was used in the patients in this series has essentially eliminated these complications, presumably by preserving the ileo-cecal valve and ascending colon. The preservation of the ileo-cecal valve and ascending colon allows for slower transient time and greater water absorption, hence less diarrhea and electrolyte losses. The preservation of the terminal ileum in addition makes parenteral B12 administration unnecessary in the postoperative period.

Carbohydrate and protein are adequately absorbed in the duodenum and proximal jejunum. Fat absorption depends on mixing with bile salts and more prolonged contact with intestinal mucosa.

Absorption studies indicate that with time there is some compensation of the jejunum and ileum left in circuit. The transient time from mouth to colon is increased and there is definite hypertrophy of the mucosa, as proven by postoperative biopsies. Thus, the xylose absorption curve which is used to measure carbohydrate absorption returns to normal or near normal by the end of 2 years. The glucose tolerance curve, however, remains somewhat flattened, indicating that glucose is not as rapidly and effectively taken up. In diabetics who have undergone intestinal bypass the glucose tolerance curves tend to be flatter and management made easier. They are still diabetic, however, as proven by intravenous glucose tolerance tests. The lessening of hyperglycemia in diabetics may have a mitigating effect on the complications of diabetics such as the development of atherosclerosis, but this point is still unsettled.

Protein absorption appears to be adequate after a shunt: serum albumin levels have remained normal and no edema has been noted with long-term followup.

Fat loss is, of course, great after the shunt. People on a 100-gram fat diet absorb 95% of the fat preshunt, but only 50-60% postshunt. This is, of course, the reason for the weight loss, with a large proportion of caloric requirements during the time of most rapid weight loss being derived from body fat. With the decrease in body fat and the slowing of weight reduction a greater proportion of nutritional requirements come from exogenous sources, thus providing more complete nutrition.

Serum lipid levels have been shown to decrease 40% after weight has stabilized post-jejunal-colic shunt, with losses appearing in phospholipid and cholesterol fractions, while triglycerides remain essentially unchanged. Lewis, et al[10] reported a corresponding decrease of 50% in serum cholesterol and beta lipoprotein fraction after jejunal-colic shunt while the serum alphalipoprotein level remained unchanged. They compared the resulting low beta to alpha-II lipoprotein ratio to that found in Peruvian and Navajo Indians, in whom the incidence of atherosclerosis is low. Payne[11] reported a more modest 25% drop in cholesterol after jejuno-ileal bypass, however, and in this series the observed drop was 41%. Ingested cholesterol can be absorbed by the entire small bowel, but there is preferential absorp-

FIG. 12.—*Weight loss as a function of the length of shunt.*

SHUNT (INCHES JEJUNUM:ILEUM)	POUNDS LOST	STABILIZED (S) LOSING (L)	% WEIGHT LOSS FROM SURGERY	% WEIGHT LOSS WITH ADDITIONAL DIETING
14:4	186	S	48%	—
12:12*	20	S	8%	—
12:12*	50	S	18%	21%
12:9	94	S	33%	—
12:8±	94	S	33%	42%
12:7	196	S	45%	—
12:7	149	S	50%	—
12:7	120	S	44%	—
12:7	177	S	49%	—
12:7	132	L	—	—
12:7	116	L	—	—

*Patient has lost an additional 10 pounds from dieting after weight stabilized.
±Patient has lost an additional 27 pounds from dieting after weight stabilized.

tion in the distal one-half. Total transient time greatly influences absorption. These two factors of course are altered with the shunt and in part account for the drop in cholesterol level. In addition, the enterohepatic pathway for the absorption of bile acids is greatly altered, since most of the terminal ileum is bypassed. Because of this there is a compensatory increase in hepatic conversion of cholesterol to bile acids.

Uric acid levels have been elevated, this being a not uncommon compliment to rapid weight reduction by whatever means.

The only supplement that is sometimes needed is extra oral potassium; however, usually a high potassium diet will suffice after the first few months.

The enzymes, though somewhat elevated in the postoperative period, return to normal with time.

As is indicated in Fig. 12, the weight loss as a function of the length of the shunt is more predictable when calculated as a percentage of total body weight rather than the number of actual pounds lost.

The 12:7 end-to-end shunt and the 14:4 end-to-side shunt, giving weight losses of 47% and 48% of total body weight, seem to be best suited to this group of massively obese patients, who are at least 100% over their ideal weight. In other series, shorter shunts have met with too many physiological complications to be considered in our patients.

Thus, although jejuno-ileal bypass may seem a rather radical treatment, this amount of obesity is a serious disease in light of present knowledge. The difficulty that people encounter in sticking with diets and maintaining weight loss has been well documented. These problems, of course, are magnified when a person reaches this degree of obesity with its attendant emotional disturbances. To give an example of the problems of reducing to a near normal size, one has only to remember that the energy content in 100 pounds of obesity tissue is about 400,000 calories, or the expenditure of calories a patient would put forth in 6 months to 1 year, assuming his mouth were wired shut.

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Can rabies become endemic in Hawaii? You can bet your mongoose.

Hawaii's Quarantine Regulations and the Epidemiology of Rabies

RICHARD I. FRANKEL, M.D., *Honolulu*

• *"Despite perennial campaigns in the correspondence columns of newspapers, nothing whatever can justify any easing of the restrictions on the quarantine regulations, for they have given this country a freedom from a grave disease that few others enjoy."*[1] *The subject of this British editorial is animal quarantine for the prevention of rabies, and reflects a situation similar to that found here in Hawaii–freedom from rabies, quarantine regulations which attempt to maintain a rabies-free environment, and periodic appearance of letters to the editor demanding an easing of the quarantine restrictions.*[2] *These letters generally seem to stir interest in the community, though fortunately they have thus far led to no action.*

When a recent legal decision enabled one individual to avoid the quarantine measures for a pet dog, neither letters to the editor nor the legal decision itself brought rebuttal or comment from the medical community. A review of the epidemiology of rabies, particularly as it pertains to Hawaii, should persuade physicians that our present quarantine measures must not be relaxed but maintained.

How important is it to maintain a rabies-free environment? Though rare patients with rabies may survive,[3] almost everyone with clinical rabies can be expected to die. In rabies-endemic areas, a large number of persons, after animal bites, receive preventive immunization, with the associated risk of adverse reaction and the discomfort of from 14 to 21 daily injections plus boosters. In 1972, although only one case of rabies in humans was contracted in the United States, an estimated 475,758 doses of rabies vaccine were distributed.[4]

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The threat of rabies in a human can be psychologically devastating. Even when patients receive what is felt to be optimal post-exposure prophylaxis, they cannot be assured they will not contract the disease. The incubation period of up to one year[5] means a prolonged period of psychological distress for the patient and physician alike. My personal experience is that there is no other situation quite so upsetting to a healthy person and to the infectious disease specialist to whom he or she is referred than exposure to an animal which might be rabid.

Many species of animal can be host to the rabies virus, as reflected in recent significant changes in the epidemiology of rabies. Whereas formerly the majority of human cases were associated with domestic animals, primarily dogs and cats, in recent years wildlife rabies has taken on added importance. From 1946 to 1949, all 48 cases of human rabies in the United States which could be traced to animal exposure were contracted from dogs (43) and cats (5). From 1958 to 1961, 8 of 15 cases resulted from exposure to dogs or cats, the remaining 7 from wild animals.[6] This trend seems to be worldwide, as skunks, foxes, and bats are playing prominent roles in the transmission of rabies.

Wildlife rabies is extremely important for a number of reasons. First, identification of rabid wildlife is obviously more difficult than with domestic animals. Second, wild animals can transmit the virus to domestic animals as well as to humans. Third, an important clinical feature of rabies in wildlife is the loss of fear of man and larger animals.[7] Thus, the features of the disease tend to favor its transmission to humans and their pets. Fourth, containment of rabid wild animals is difficult. Often the biting animal cannot be found; immunization is generally recom-

mended after sustaining a bite by or having contact with the saliva of any wild animal in a rabies-endemic area. Thus, immunization is frequently necessary where wildlife rabies is endemic, even though the number of cases may be small.[8]

As an area free of foxes, skunks, and bats, is there any risk of establishment of rabies in wildlife in Hawaii? The answer is obviously yes (or I would not have written this paper!). The mongoose, a small carnivorous mammal of the family *Viverridae,* was introduced into Hawaii in 1883 in an attempt to destroy rats which were damaging sugar crops. (It had been brought from India to the West Indies for this purpose, and then sent from there to Puerto Rico and Hawaii. It has been as unsuccessful as an agent for rat control in those areas as in this state.) The mongoose is now considered to be the maintenance host of wildlife rabies in Cuba, Puerto Rico, and Grenada.[9]

Rabid Mongooses

The epidemiology of rabies in Puerto Rico may serve as an example of the potential course of this disease in Hawaii. Puerto Rico had been considered rabies-free from 1933 to 1950, when a rabid dog was found and a subsequent rural outbreak of rabies was noted in domestic animals. All of the dogs involved had recently fought with mongooses, and studies demonstrated rabies to be widespread in the mongoose population in Puerto Rico.[10] The disease was shown to have spread from the mongoose to dogs and other domestic animals.

Puerto Rico reported 49 cases of animal rabies in 1974; 40 of these were in mongooses, 6 in dogs, and 3 in other domestic animals.[11] Other countries have shown similar patterns. In Grenada, an average of 25 persons per year received post-exposure rabies prophylaxis from 1968 to 1974. Of these exposures, 55% were a result of mongoose bites. An average of 61 cases of mongoose rabies occurred each year.[12]

Most of the dog exposures can be presumed to represent secondary exposure to mongooses which initially transmitted the disease to the dogs. As previously mentioned, behavior of wild animals often changes when they develop rabies. The normal mongoose has a natural fear of man and many animals. It may become vicious when cornered or caged, however. When rabid, the mongoose exhibits extreme hyperexcitability and ferocity. Two experimentally-infected animals suffered broken teeth, lacerated muzzles, and severe oral trauma from biting at their cages.[10]

In South Africa, a variety of mongooses serve as rabies reservoirs. Children are often bitten by animals which wander into houses and may be approachable because of the effects of the disease.[7]

Is Quarantine Effective?

If one accepts the premise that the mongoose population in Hawaii represents a potential wildlife reservoir of the rabies virus, and that it is therefore mandatory to attempt to maintain a rabies-free environment here, the next question is whether quarantine is an effective method of attaining this goal. In this regard, it is useful to look at the experience in Great Britain. Rabies had been epizootic and endemic in Britain until the advent of public health measures in the 19th century. The disease was considered to be eradicated in 1903. Since that time, the only cases (with a single exception) have been attributed to animals illegally smuggled into the country.[13] As Kaplan has noted, "Many of the large islands—Britain, Hawaii, Cyprus, and New Zealand, for example—are free of the disease largely because of rigidly enforced stringent regulations concerning the entry of dogs and cats."[7]

Britain's Experience

Although Britain has been rabies-free and has had stringent regulations (including quarantine), in 1972 the British Central Public Health Laboratory issued 1137 doses of rabies vaccine for pre-exposure prophylaxis and 591 doses for post-exposure treatment.[14] This experience, as well as the concern in England brought on by a specific incident to be described below, brought about the Rabies Act of 1974, ordered by the Ministry of Agriculture, which took effect on February 5, 1975. Among the act's provisions are:

(1) Destruction of animals entering the country illegally;
(2) up to a year's imprisonment for the smuggling of animals;
(3) destruction of foxes (a potential wildlife reservoir—previous attempts at mongoose population control in other countries have failed); Author's comments in parenthesis.
(4) controls on the movement and vaccinations of pets;
(5) seizure of stray animals;
(6) banning of hunting;
(7) banning of cat and dog shows.[15]

In spite of geographic isolation, introduction of rabies is a constant threat and preventive measures, including quarantine, are necessary.

If quarantine is a reasonable control measure, what duration is required? The public often demands a reduction of the present 4-month quarantine. Several facts are pertinent. Just as in the human, the incubation period for rabies in animals is quite variable. Periods of up to 109 days in foxes[16] and 172 days in skunks[17] have been reported. Some animals with rabies may be asymptomatic;[18] the period of contagiousness of these animals remains to be defined. In Britain, in 1969, a dog died 14 days after completion of

quarantine (at that time 6 months). A total of 23 persons received preventive anti-rabies treatment because of exposure to this one animal.[19] In 1970, a dog died of rabies 3 months after completing the 6-month quarantine.[20] The quarantine period was extended from 6 to 8 months,[20] and subsequently was extended to one year.[21] After a temporary total ban on importation of animals,[22] a policy was enacted adopting a 6-month quarantine period in conjunction with rabies vaccination of all quarantined animals.[23] Cumulative data from 1919 show that of 77,000 dogs and cats quarantined in Britain, 29 developed rabies while in quarantine. Of these, 7 developed the disease after being in quarantine longer than 4 months.[7] Thus, one authority recommended a 4-month quarantine period, in addition to owner surveillance of imported animals up to one year after importation.[7]

The risks to Hawaii of importation of rabies are clear. There will be no way of assuring that the virus does not become established in our mongoose population. As noted, rabid mongooses will pose a direct threat to the population. Additionally, 1970 data show a state population of 85,000 dogs and 65,800 cats.[24] These represent household pets, and do not take into account wild animals. With a large number of pets in a small area, the risk of spread of infection to these animals from the mongoose is significant. Thus, physicians and patients in Hawaii will be faced with difficult and unpleasant decisions regarding post-exposure rabies prophylaxis.

The evidence cited above shows that even a 4-month quarantine may not always be sufficient. There certainly can be no rational argument for shortening the quarantine period. If the quarantine facilities are not adequate from the point of view of the animals' comfort and health, then the facilities should be appropriately modified, and the cost of maintaining the quarantine operation should be passed on to those whose animals are housed there. In addition, control programs to prohibit smuggling of animals by boat or plane should be reviewed to assure their effectiveness.

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JON WON

The U. S. Public Health Service is preparing to visit the Honolulu area to conduct a Health and Nutrition Examination Survey of persons aged 6-months through 74-years. The initial phase to begin February 10, 1978 with interviewers going to selected households to obtain demographic information and to select 315 persons for examination. Exams will be conducted February 25 through March 23, 1978, in the Survey's mobile examination center. If you wish to know more about this survey, call the HMA office for more information.

Food and Drug Administration of DHEW announces a series of regional meetings for professionals to provide an opportunity for direct exchange of information and ideas on new developments, issues and mutual concerns between health professionals and key FDA staff. Thus far, regional meetings have been scheduled as follows: February 1—Philadelphia; March 1—St. Louis, Mo.; March 31—Dallas; April 21—Atlanta; June 9—New York. Additional information available at HMA office.

National Endowment for the Humanities announces plans to continue in 1978 Humanities Seminars for Medical Practitioners which occur during the summer at selected colleges and universities. These seminars bring physicians and other health professionals together for a month of full-time study under direction of distinguished philosophers, historians, and others, and will give participants a chance to explore the humanistic dimensions of their professions such as, history of professional ethics in American medicine, moral dilemmas in medical practice, and the relationship between individual and public rights in health care. From 12 to 15 persons will attend each seminar tuition-free, receiving a stipend up to $1200 to cover expenses, plus reimbursement for travel. Application deadline is April 17, 1978. Further info from: Professions Program, Division of Fellowships, National Endowment for the Humanities, Washington, D. C. 20506.

Harris Survey in Late 1977 as to the public's confidence in major institutions showed that **medical leadership ranked at the top.** The results in this poll on public confidence: Medical leadership—55%; Higher education—41%; Organized religion—34%; U. S. Supreme Court—31%; the Military—31%; television news—30%; White House—26%; major companies—23%; executive branch of government—23%; local government—21%; state government—19%; the press—19%; law firms—16%; Congress—15%; organized labor—15%; advertising agencies—11%.

The Hawaii Epilepsy Society would like to inform all physicians that it now has a full-time social worker on its staff and is pleased to accept clients for counseling and referral. While there is no charge, physicians should make appointments for patients by contacting Reenie Christensen at 536-9685.

Conference on the Family in Hawaii has been organized to provide an educational and action forum on the family for Hawaii residents and professional agencies and organizations. The Conference is to be organized around the major themes of The Forces for Change, the Consequences of Change, and Directions for the Future with each to be developed through keynote addresses, panel presentations, and workshops. The Conference has tentatively scheduled its first events for March 21 through March 24, 1978. Additional info available at HMA office.

Correction, Correction: The winner of the singles tennis event at the HMA Annual Meeting was incorrectly reported. It was Dr. Benjamin Chang that won the Singles Tennis Tournament. Drs. Chang and Maehara were the winners in the Doubles Tournament.

Available: IE104 exam table as well as office space in the Pearl City area by the day, up to 270 sq. ft. Interested physicians contact HMA office for phone number.

The Hamakua Infirmary in Honokaa, Hawaii, seeking general surgeon to join its' four-physician clinic. Require board certified or board eligible surgeon for this unique position. Interested surgeons contact HMA office for details.

Wanted: Pediatrician with training in pediatric pulmonary disease to develop ambulatory follow-up program. Faculty appointment at rank of Assistant Professor.

Also wanted is Pediatrician to assist in developing a continuity care training program. Faculty appointment at rank of Assistant Professor. Training and experience in ambulatory care desired. For either position, contact S. L. Hammar, M. D., Dept. of Pediatrics, John A. Burns School of Medicine, University of Hawaii, 226 North Kuakini Street, Honolulu, Hawaii 96817.

Recruiting: Family practitioner/general practitioner for hospital-based group practice. Contact F. Stenson, Director, Primary Care Center, St. Francis Hospital, 2230 Liliha Street, Honolulu, Hawaii 96817; Phone 547-6535.

The Hawaii Council of American Indian Nations forming a task force on Indian health to be composed of American Indian people from medical, dental, and mental health professions. The task force to assess health needs of 2 to 3 thousand American Indians residing in Hawaii. Interested physicians, especially of American Indian descent are asked by the Hawaii Council of American Indian Nations to become involved. More details from HMA Office.

Urgent Appeal has gone out to public by India Association of Hawaii for assistance to the India Cyclone Relief Fund. The disastrous cyclone and subsequent tidal wave that hit the southeast region of India in November, 1977, destroyed over one million acres of agricultural and farmland, ravaged hundreds of villages, killed more than 20,000 people (so far accounted for), and left hundreds of thousands more homeless and in peril. The drive for assistance in Hawaii is conducted in cooperation with the American Red Cross. Any one wishing to assist can contact the HMA office for more details.

Physicians are Urged to be Cautious about revealing their AMA assigned Medical Education Numbers, especially to governmental and other agencies where there is a concern for the confidentiality of physician data. Your Medical Education Number is an eleven digit number. The first seven digits are public information which identify the state of your medical school, the particular school, and the year you received your M. D. degree. The last four digits represent your own personal identifying number. The AMA utilizes the entire number in processing membership lists for invoices, etc. This is priviledged information and should be handled as such.



Outreach from an M.D.—the PA

The medical profession and the various State Legislatures have been geeing and hawing for some time with respect to the role of the Physician's Assistant (PA) or Extender and his (more often her) rights, responsibilities and fees for service.

There are a few basic principles involved. One is certification versus licensure. Another is the degree of supervision, usually mandated by law, and the length of the apron string. The third is the amount of the fee for the service provided by the PA.

Let us consider the latter.

The whole idea and thrust of a PA system is to lower the costs of medical care. In this day and age of too many people and too few medical doctors, it makes sense to explore the Chinese (Mainland) system wherein there is a big push to educate each person to take care of his own health first—either via prevention, or, if disease or injury strikes, by the application of simple medical knowledge to simple self-care. Then, if it doesn't work out, ie, no improvement occurs, one is to call for the slightly greater expertise of the "barefoot doctor" who is, in actuality, a PA or partially trained practitioner of both "traditional" and "western" medicine. This one, in turn, will refer the case as far up the line as seems indicated, by a form of triage. In theory, this system should work perfectly. The "line" extends from the cheapest to the most expensive, commensurate with the degree of sophistication of medical care that is needed.

Here in this country of ours, however, there enters into the picture the factor of liability, and this complicates the matter of how much to charge.

On the face of it, the fee for the service of a PA should not be anywhere near what the physician considers to be his own usual, customary and reasonable one. How much less it should be may be difficult to establish. The farther away the PA

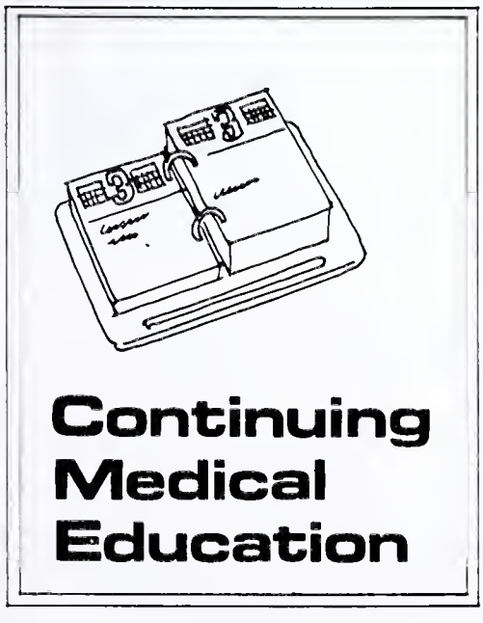
is from direct supervision, the larger the fee might be, perhaps, since his own responsibility is the greater.

However, the factor of the physician's liability, and the insurance coverage for it—almost mandatory in our society—makes it almost necessary that the medical doctor charge the patient the same as if he had performed the service himself. Obviously, then, the benefit of a lower level of care that is adequate to the patient's needs, will not be reflected in lower costs. What's more, third party payors generally exclude such services from their health care plans as being noncompensable.

Only in Health Maintenance Organizations (HMO's) is it feasible to develop a system of medical care that can really provide an incentive for the role of the PA. Since the HMO is a self-contained (financially speaking) unit providing medical care for a captive membership for a fixed total dollar amount, it can hire PA's for whatever they are worth in dollars; the patient gets the service anyway and needs not to be concerned about the cost.

But, even in HMO's, the matter of liability and responsibility is a large and important factor in our country. It may be this item that precludes the instant and overwhelming success of HMO's that the Feds have expected, and have found to be miserably wanting. A few physicians cannot safely rely on a large staff of PA's, in order to make an HMO financially solvent and be a "cheaper" form of medical care. Neither are the people of this country going to be satisfied with the service of a PA, when they are already used to first class care by a physician.

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division
1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine
1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
3. U.H. Cardiology Grnd. Rnds., 1st Tues. 5:30 p.m. Rm. 506 Univ. Tower, Queen's.

Kaiser Hospital
(Contact CME Dept. for further information)

Kauikeolani Children's Hospital
1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital
1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital
1. G.I. Conference, 3rd Tues., 8-9 a.m.
2. Medical Mortality & Morbidity, 4th Tues., 1:00-2:00 p.m.
3. Endocrine conf., 2nd Wed., 1:00-2:00 p.m.
4. Oncology Conf., Every Thurs., 7:30-8:30 a.m.
5. Surgical Mortality & Morbidity, 4th Fri., 1:00-2:00 p.m.
6. Visiting Prof. Programs.
7. Ophthalmology Dept. Mtg. 1st Tues., 1:00-2:00 p.m.
8. Surgical Conf. 2nd & 3rd Fri., 1:00-2:00 p.m.

(Contact: CME Dept.-Kuakini for further information)

The Queen's Medical Center
1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic
1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.

3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professors' Program.
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

St. Francis Hospital

1. Orthopedic Dept. Conf. 3rd Fri. ea. month. 7:30 a.m.-Med. Staff Board Rm.
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
7. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.
8. Dept. of Medicine Monthly Mtg., 2nd Tues. ea. mnth. 7:45 a.m. UH 1V Classroom.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu
Type: 1, 1 hr/day, 1 day/mo from 12 mos
Fee: None Methods: AV, O, Pan
Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: 1, 1 hr/day, 1 day/mo for 8 mos
Fee: None Methods: AV, Clin C, O, Pan, R
Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

Feb. 1-3, 1978	Post-Conf. Workshops at Htl. King Kamehameha-Kailua-Kona. Estes Prk Inst. Box 400, Englewood, CO 80151. 3 days-10 hrs. Fee $100.
Feb. 6-7, 1978	"Living & Dying With Cancer," 2 day symposium, Ala Moana Htl. Honolulu. St. Francis Hsp.-Cancer Rehab. Contact: Patricia Hanna, M.S., R.N. (808) 547-6474. 16 hrs. Cat. I.
Feb. 20-24, 1978	Advances in Pt. Care: Caring for the Older Person at Kona Surf Htl., Box 128, Kailua-Kona 96740. 5 days-31 hrs. Med. Comm. & Serv. Assn., 315 Univ. Dist. Bldg. 1107 NE 45th St. Seattle, Wash. 98105.
Feb. 27, Mar. 2, 1978	Winter Trav. Med. Educ. Course at Royal Lahaina Htl., Maui, Hl. 4 days-10 hrs. Fee $100. Kansas City SW Clin. Soc. 2220 Holmes St. K.C., MO 64108.
Feb. 27-Mar. 3, 1978	Clin. Mang. of Sexual Problems at Sheraton-Molokai Htl., Molokai, Hl. 5 days-30 hrs. Fee $195. Med. Comm. & Serv. Assn. 315 Univ. Dist. Bldg. 1107 NE 45th St., Seattle, Wash. 98105.
Feb. 27-Mar. 3, 1978	Surg. Diagnosis & Therapy at Maui, Hl. 5 days-20 hrs. Fee $300. Phil Thorek Post-Grad Courses, 850 W. Irving Park Rd., Chicago, IL 60613.
Mar. 7-8, 1978	Update on Tuberculosis; Ala Moana Htl. Honolulu. Co-Spon. Am. Lung Assoc. & Center for Disease Control, Atlanta, Ga. Contact: Rosemarie Respicio, (808) 537-5966 for further info. No fee.
Mar. 13, 14, 15, 1978	Child Neurology for the Practicing Pediatrician-update. Shriner's Hsp. Aud. Co-Spons: Dept. of Ped-John A. Burns Schl. of Med. & Kapiolani-Chldrn's Hsp. Contact: Wilma Schiner, Workshop Coord. 1319 Punahou St., Honolulu, HI 96826.
Mar. 14-18, 1978	Sports Med/Primary Phys. at Princess Kaiulani Htl., Waikiki, Hono., Hl. 5 days-18 hrs. U. of Hl Sch of Med. 1960 E West Rd., Hono 96822 & Amer Acad of Family Prac. Contact: Harold Brown, (808) 373-3745 or 373-3045.
Apr. 3, 7, 1978	14th Congress Pan-Pacific Surg. Assoc. Hilton Hi Village, Honolulu, Hl., 7:30 a.m.-12:45 p.m.. For details write: Cesar B. deJesus, M.D., 236 Alex. Yng. Bldg. 1077 Bishop St., Honolulu, Hl 96813. (808) 536-4911.
Apr. 16-22, 1978	Diving Medicine (General), Held at King Kamehameha Htl., Kailua-Kona, HI. 6 days-25 hrs. Cat. 1. U of Hl Schl. of Med. 1960 East-West Rd. Honolulu, 96822. Contact: Dr. E. L. Beckman, Dept. of Physiology (808) 948-8652 or Harold Brown (808) 373-3745 or 3045.
Apr. 17-21, 1978	Emergency Med., 1978 at Royal Lahaina Htl., Maui, Hl. 5 days-30 hrs. U of So Calif
Sept. 20-23, 1978	Genetics & the Pediatrician—What Every Ped. Should Know.—Held on Oahu & Maui. Contact: Wilma Schiner, Workshop Coord. Kapiolani-Chldrn's Hsp. 1319 Punahou St., Honolulu, Hl 96826 for further info.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.

1978 Workers Compensation Fee Schedules Now Available at HMA Office.



New Members



Hilarion C. Dayoan, M.D.
GENERAL PRACTICE
94-801 Farrington Highway
Waipahu, Hawaii 96797



James E. Musgrave, M.D.
PEDIATRIC NEPHROLOGY
1380 Lusitana Street
Honolulu, Hawaii 96813

Hawaii Academy of Family Physicians' Newsletter

J. I. Frederick Reppun, M.D.

New Members—Joe Fitzharris MD is a Resident-Affiliate from TAMC; **James Walker,** UHSM'81 is a new Student member, and **Nathan Wong MD** is another Resident-Affiliate from Kaiser. Welcome aboard! The Council decided to include Resident-Affiliates on the Council, and the above two are up for election at the annual meeting this month.

News of Members—long-time member and charter member **Bill Walsh** has been accepted as a Fellow of the International College of Surgeons. Don't get too close to those butchers, Bill! We were happy to see **Homer Benson's** better half Kay enjoying a party and recovering from Homer's Disease: An AMI.

Condolences—to another long-time member **Al Burden** of Maui, on the loss of his good wife Helen.

H.M.S.A.—Toru "Blue" Nishigaya retired as Medical Director of HMSA in September. He is succeeded by psychiatrist Henry K. Watanabe. Tany S. Hong, Deputy Attorney General of the State, has ruled that HMSA is in no violation as regards its relationship with Non-pars and the patients of Non-pars. "The nonpars are strangers to the contracts . . ." and "The same is true for members who voluntarily choose the services of a nonpar."

ABFP—a reminder: The deadline for applying to take the certifying boards is 1 April 78 under the old criteria; thereafter, only those who have been in Family Practice Residency programs may qualify to be certified every six years.

Core Content Review—13 members from the Hawaii Chapter are taking this Connecticut & Ohio six-month 24-credit "P" course; Our 21.3% of Active members puts us 3rd from the top participating states. Material benefits to the Chapter include a check for $65 to swell the kitty! There is still an opportunity to participate in a "recycled" course beginning on 1 February. A computer analysis of how our State did on the 1976-1977 CCR reveals that "without using a book,"

Announcing the

41st Annual New Orleans Medical Assembly

March 31 - April 4, 1978
The Fairmont—New Orleans

THE HIGH RISK PATIENT

Accreditation: AMA Category I, Physicians' Recognition Award, American Academy of Family Practice, American College of Emergency Medicine, Category I.

Adolph A. Flores, Jr., M.D., President; Oliver H. Dabezies, Jr., M.D., F.A.C.S., Director of Program.

Registration Fee: $200 non-member physicians; $100 military; $100 registered nurses; Complimentary: students, residents, interns and Fellows.

Write or Phone: New Orleans Graduate Medical Assembly, Room 1538, Tulane Medical Center, 1430 Tulane Ave., New Orleans, LA 70112. Call (504) 525-9930.

• Presidential Reception • Exhibitors' Champagne Reception • Mississippi River Cruise aboard SS Natchez • Superdome Tour, luncheon & fashion show for wives & guests.

Spring Fiesta, March 31, 1978. "A Night in Old New Orleans," Jackson Square.

we did well in Infective & Parasitic Diseases, Diseases of the Respiratory System, and surpassed the national average by 28.7% in Pediatrics. However, we did poorly in diseases of the nervous system, musculoskeletal, ill-defined conditions and 22% below the national average on diseases of the blood & hematopoetic system. (I think it was I who pulled everyone down!)

CME—We have had only one member participate in the Georgia AFP's Family Medicine Refresher Course 100. Enrollment deadline is 17 April 1978. The Washington AFP is sponsoring a "Ski Learn 78" at Crystal Mountain on 7-10 February 1978.



October 21, 1977
HMA Conference Room

PRESENT

Drs. C. Sia, M. Hanlon, G. Batten, D. Bell II, H. Chinn, W. Iaconetti, T. Magoun, G. Goto, L. Howard, J. Edwards, C. Kam, R. Lichter, S. Uehara, A. Wigle, E. Ho, R. Kuboyama, W. Moore, W. Dang, A. Catts.

MINUTES

The minutes of the September 2, 1977 meeting were approved as circulated.

EMERGENCY MEDICAL SERVICES

Senator Anson Chong will be holding an open hearing soon on new health bills and bills that have been carried over to the 1978 legislative session from 1977. Sylvia Levy presented three areas of testimony that EMS would like to speak on at that hearing.

(1) Presently, over 95% of the citizens of Hawaii are covered by Health Insurance and EMS feels that there is no further need to have free ambulance service in Hawaii. They would like to request that part of the revenue gained by charging for ambulance service be subcontracted to HMA for maintenance of equipment, continued training of ambulance personnel and modernization of the service. Their bill would repeal Section 46-14 of the Hawaii Revised Statutes regarding free ambulance service.

ACTION:
It was voted to accept the concept of paid ambulance service for Hawaii.

(2) A draft resolution prepared by EMS requests an appropriation to support and maintain the HMA-EMS as a center for the training of first responders and emergency medical service personnel which would be made available to all levels of government and overseas assistance programs who might utilize such personnel. Federal funds will expire in whole or in part in fiscal year 1978-79.

ACTION:
It was voted to accept the concept that the State of Hawaii support the HMA-EMS program and that the support be forthcoming during the interim between the lapse of federal funds and permanent planning.

(3) A second resolution requests the legislative reference bureau to conduct a study of the HMA-EMS program and make recommendations regarding, among other items, establishing a "center of excellence" explained in #2 above and the most economical, efficient and effective method of assigning management, regulatory, training, data systems, planning and evaluation responsibilities among the State and County governments, and the HMA. Certain Council members felt that the resolution should be rewritten to reflect a more positive attitude toward the program suggesting that the Dept. of Health be assigned the regulatory functions and EMS assigned training responsibilities. This resolution will be rewritten and presented to the House of Delegates for action.

TREASURER'S REPORT AND FINANCE COMMITTEE REPORT

A. September 1977 Financial Statement: The September 1977 financial statement was reviewed in detail.

ACTION:
It was voted to accept the report subject to audit.

B. Budget for 1978: The proposed budget for 1978 was discussed at the September 2 Council meeting and mailed to all members prior to the October 21 meeting.

ACTION:
It was voted to present the 1978 Proposed Budget to the House of Delegates.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. Building Committee: The Building Committee has been investigating other methods of re-financing the 320 Ward Building, however, before a financial institution will consider converting the present Agreement of Sale, an up-to-date appraisal of the building must be secured.

ACTION:
It was voted to approve an appraisal by Mr. John Hulten at a cost of $1000 or less.

B. Self-Insurance Committee: The Self-Insurance Committee continues to investigate the proposal of Mr. Paul Brown for a physician-owned stock insurance company. It was Dr. Edward's opinion that an appraisal of this proposal should be obtained by an actuary hired by HMA. Mr. James McGinty was suggested as a possible actuarial consultant.

ACTION:
It was voted to negotiate with Mr. Jim McGinty to give an actuarial report and evaluation on Paul Brown's Proposal for $3000 or less. There was one objection.

C. Public Safety Committee: Dr. Jon Pegg, at the request of HMA, sent samples of Diving Medicine Medical Examination Forms that could be used by physicians for examining scuba divers. The Council felt that the Public Safety Committee should investigate the development of specific criteria for examining commercial divers. Dr. Sia will write to Mr. Kenjii Ego of the State Dept. of Fisheries, since he had corresponded with HMA as to whether examinations should only be performed by those physicians trained in diving medicine, outlining the Council action stated below.

ACTION:
It was voted to recommend that any physician could perform a medical exam on scuba divers using the forms in Attachment II, not just those physicians who have had special diving medicine training.

D. Cancer Committee: Dr. Herbert Chinn, Chairman of the Executive Committee of the Cancer Center of Hawaii, wrote to Dr. Sia on October 6 indicating that recent cutbacks in financial support will make it impossible, as of December 1,

1977, for the center to provide free estrogen receptor assays for breast tumors.

ACTION:

A motion was made that the Cancer Center discontinue estrogen receptor assays and that a commercial laboratory in the community establish the assay on a fee for service basis with recovery through a third party. The motion passed.

E. Executive Director's Salary: The Council went into Executive Session to discuss the salary of the Executive Director to be effective January 1, 1978 provided that the proposed budget is approved by the Houe of Delegates.

ACTION:

It was voted to approve an adjustment in the Executive Director's salary subject to approval of the budget for 1978 by the House of Delegates.

F. Leadership Conference: Material was distributed to all Council members regarding the Leadership Conference held October 2, 1977 at the Princess Kaiulani Hotel. Dr. Sia encouraged any and all members of the Council to develop Resolutions, if they so wish, which would help HMA carry out some of the main ideas that were expressed at the Leadership Conference.

G. National Health Insurance Hearing: A hearing on National Health Insurance will be held in Honolulu, Wednesday, October 26 from 9 AM to 9 PM. Dr. George Mills will provide testimony on behalf of HMA. Dr. Sia will probably choose another physician to represent HMA also at the hearing.

H. County Society Reports: Kauai County Medical Society and Maui County Medical Society had nothing new to report.

Dr. Catts noted that the September 13 Public Forum held by HCMS, similar to the HMA Leadership Conference, was very successful. The HCMS Planning Committee will be following up on the ideas presented at the forum. Since the last Council meeting they have also had a membership meeting on October 4.

I. HMA Auxiliary. Mrs. Fred Shepard reported that the Legislative Workshop held October 3-5 was excellent. Pat Saiki provided good leadership and Mrs. Shepard had nothing but favorable remarks about the meeting. The auxiliary is most anxious to help HMA in the upcoming legislative year.

J. Commendation for the Outgoing President and Council: The Council voted to commend Dr. Calvin Sia for his efforts this past year as President of HMA and Dr. Marion Hanlon thanked the outgoing Council members (Drs. Albert Chun-Hoon, George Goto, J.I.F. Reppun and Leonard Howard) for their participation and attendance during the term as Councillors.

ADJOURNMENT

The meeting was adjourned at 8:30 p.m.

DOUGLAS B. BELL, II, M.D.
Secretary

PERSONNEL-ITY OF THE PACIFIC
"The Personnel Specialists"

Dear Doctor:

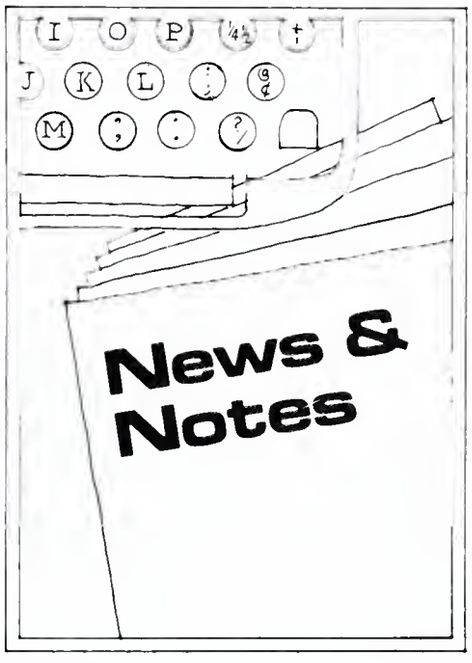
Could your practice continue without a competent staff?

Yet, isn't it more important for you to use your time in the care and treatment of patients? You should not have to spend valuable time locating staff people.

Whether your needs are in the lab, the clinic, or the front or back office our professional counselors can evaluate applicants' qualifications objectively. We can do the advertising and preliminary interviewing and refer only a few TOP QUALITY people for your selection.

S. Cabacugon, M.D.
S. Cabacugon, M.D.
Medical Division

1441 Kapiolani Blvd./Suite 1203, Honolulu, Hawaii 96814/Phone 955-6686



HENRY N. YOKOYAMA, M.D.

Professional Notes

In December and January, the parade of physicians moving into the Queen's Physicians Office Building continued unabated: In December, came general and vascular surgeon, **Thomas Whelan,** and the Medical Associates, including internists **Max Botticelli, Christian Gulbrandsen,** and **Dennis Meyer.** They were followed by nephrologist **Robert Hinman;** Ophthalmology Ltd, viz **Gerald Faulkner** and **Wayne Wilson;** Ob Gyn man **Lockwood Young;** and plastic man **Bennett M. K. Lau.** With the New Year of the Horse came urologist **James Young;** dermatologist **Claude Caver; Noni Brar Koch** (specializing in adolescent gynecology and family planning); and internist **Frederick Fong.**

In other areas, during December, orthopod **Masao Takai** associated with the Fronk Clinic; psychiatrist **Genesia Liu Rogers** joined the Straub Clinic; **Jack Paldi** joined Internist Clinic Inc at 1441 Kapiolani Blvd; internists **Quintin Uy** and **Marina Bumanglag** opened a branch office in Pearl City and internist **Corazon Cadiz Hobbs** opened a clinic at 94-216 Pupukahi St, Waipahu. On Kauai, family practice specialist **Mark Wentworth** joined the Waimea Clinic after serving at Tripler from 1973 to 1976. We are seeing more of our UH Med School graduates returning to practice. Pediatrician **Bert Akitake** joined the Maui Medical Group after finishing at Tulane and training at Columbus Children's Hosp in Ohio.

In January, surgeon **William Morioka** opened his solo practice at Suite 339, 1481 So King St; pediatrician **Hoon Park** opened at the Queen Emma Bld, Suite 308; internist and pulmonary disease specialist **Joseph Palma** opened at the Kailua Professional Center, Suite 302 and our jogging cardiologists **Jack Scaff** and **John Wagner** relocated to Kukui Plaza Medical Associates, Suite C-211, Kukui Plaza Mall.

Hors de Combat

The following account by a disgruntled patient is printed in toto for it is witty, humorous and somehow strikes true: "*Trying the Patience of Patients*" By Lois Taylor, *Star-Bulletin* writer . . . "Have you ever wondered why they call someone who goes to a doctor a "patient?" Because it's the one trait you need above all others while sitting out the enforced waiting period in his office. 'Patient' is defined as 'exercising forbearance under provocation, long suffering.' See?

It's not the old magazines or the phony cheer of the waiting room with its motel furniture and soothing canned music. It's not even the white knuckled insecurity of not knowing what's wrong with you.

More than anything else, it's the arrogant presumption that The Doctor's time is worth so much more to him than yours is to you that it really doesn't signify if you have a 10 am appointment and he finally sees you in the examining room at 11:30 am.

It's assumed that you haven't anything better to do than to thumb through copies of 'Today's Health' that are so old that they recommend leeches. In the meantime, the doctor can be presumed to be the center of attention in a hushed operating theater, performing some lifesaving organ transplant, even if he's a dermatologist or a psychiatrist.

As a matter of fact, he may be busy confirming arrangements to attend international medical meetings on foot faults and weak backhands in Forest Hills, New York, and Wimbledon, England.

Dentists, who do not pursue such a status-y trade as doctors, are insecure about leaving their patients very long in a waiting room, and chiropractors are right on time.

Waiting for the doctor is generally split into two phases. There is the outside waiting room period when you sit around and wonder what's wrong with everybody else; and the examining room pause when you wonder what's wrong with you.

On the whole, the latter is worse because there's nothing to do in that little white room but read the labels on the disinfectant bottles and worry about what all those odd-looking shiny instruments are for.

Furthermore, the nurse has left you with a thermometer in your mouth and wearing one of those sleazy examination gowns that is meant to tie down the front, but half of the strings are missing. The temperature in these rooms is intentionally kept at slightly above freezing so you won't spoil while you're waiting.

Occasionally, in an effort to make the room more homey, the doctor will post cartoons from the American Medical Association bulletin on the walls. These are rarely funny to anybody but another doctor.

So how can you avoid cooling your heels and other vital parts in an arctic examination room? You could arrive an hour late, but by then your appointment would have been canceled and your chart sent to the pediatrics department where they would diagnose colic.

Sometimes you will be routed through the laboratory, wandering down long halls with your little glass specimen bottle modestly draped in a paper towel. On this trek, you will meet all sorts of people you haven't seen in years, and each will comment on how you looked better the last time you met. For that matter, they did, too, but you gain nothing by being crabby.

It does no good to ask the nurse for her educated guess on how much longer you'll have to hang around. They are taught in nursing school to say, 'Doctor has been detained by an emergency,' in a hushed and sincere voice. This can mean anything from a flat tire to losing his glasses, and does not imply any medical overtones.

Eventually, the doctor arrives, and after he's decided what's wrong with you, he won't tell you. For that pronouncement, you are herded into his office.

All doctors' offices look alike because there is a national agency that supplies each one with family pictures of a wife and two children, framed and ready to set between the digital clock and the 'No Smoking, Please' sign on his desk.

The same agency turns out the diplomas hanging on the wall that came from funny schools you've never heard of.

So three hours after you arrived, you find out that there is nothing wrong with you that losing 10 pounds and quitting smoking won't cure. And the doctor says with a tight little smile, 'It's always better to check on these things, even if it does waste my time."

[May we just add: *Touché!*—Ed.]

Life in These Parts

You just can't win . . . You are caught in the 7:30 am creeping 4 lane Ewa bound Kapiolani traffic approaching Kalakaua . . . Here's a guy in a faded Cadillac anxious to cut in . . . So you stop to let him . . . But no . . . he keeps nosing straight ahead through all 4 lanes, the length of his car blocking at least three lanes . . . And you lose another 5 minutes . . .

Senator Dan Inouye has introduced a bill which will allow medical malpractice victims the option of a "No-Fault" system of compensation without lengthy negligence litigation. Dan had introduced a similar bill in 1975 . . .

Parker Ranch owner Richard Smart had offered back in March 1977 to put his entire estate into a trust to build and operate a hospital in Waimea next to the Lucy Henriques Medical Center, but his offer still had to go through channels. A special ad hoc planning committee was finally formed and will investigate what type of health care facility and services, if any, are needed for North and South Kohala and Hamakua . . . This "certificate of need" screening process is an effort by the State and Federal to regulate the building and expansion of medical facilities and services. "The intent is to emphasize the avoidance of unnecessary duplication" says Medical Center administrator and committee member **Mark Sperry.**

DSSH director **Andrew Chan** has his problems . . . It seems that the rapid increase in the welfare population, coupled with a drastic increase in the usage of medical services will cost the Medicaid program $12-million over the budget by the end of the 1978 fiscal year. Medicaid is 60% state funded and 40% federal funded. Andrew cites hospital in-patient cost rise of 51% and physician services rise of 65%. Between 1975 and 1977, the hospital bed cost rose from $107.30 to $161.95 and the physician visit cost rose from $16.41 to $27. He also noted that raising the physician reimbursement rate in 1976 has increased the Medicaid budget, but has encouraged participating physicians to increase the number of Medicaid patients they are willing to treat.

Thomas Burch, chief of the DOH Research and Statistics Dept studied 13,099 single live births and 131 new born deaths between 1968 and 1975 and concluded that babies conceived within 27 weeks after a prior birth have a high risk of death within the first month of birth. He also reported that the new born death risk was great when the birth weight was less than 1500 grams, if the mother was Japanese, if the mother was between 25 and 34 years old and if the mother had less than 3 prior births . . .

Elected, Appointed & Honored

On the academic front, internist **Bernard Fong** has been elected a fellow of the American College of Cardiology (ACC) and general surgeon **William Walsh** elected a fellow of the International College of Surgeons . . . **Daniel Sowinski,** Hilo physician, was one of five chosen from Hawaii to represent Hawaii's Rotary Clubs on an exchange with a chapter in Mexico . . . HMSA medical director for the past 10 years, **Toru Nishigaya** retired on Sep 30 and psychiatrist **Henry Watanabe** was appointed the new director . . . (We are happy to report that widower Toru Nishigaya has recently wed Kainuma's widow, Mildred)

Sportsmen

Francis Au tells us that he and **Dick Ando** were jogging together earlier last year . . . Francis had to drop out when he developed PVC's. Dick kept going and made the 1977 Marathon . . . Francis is back jogging again . . . We met **Jim Benneth** looking trimmer than ever. He whispered that his time was 3:37 . . . We still have no final report on all physician

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marathon runners . . . If anyone comes up with a list, please contact us . . .

We inadvertently won the dubious honor of the 1978 HMA Golf Tournament chairmanship and have asked three others to be co-chairmen viz **Bill Dang** (for his organizational experience) **Tom Kobara** (for his talent for raising prizes) and **Jim Navin** (for his golfing skill, intellect and his connections with military courses) . . . Thus far, we have sent letters to the Leilehua Golf Course asking for Thursday starting times on Oct 5 and to Mid Pac Golf Course for Wednesday starting times on Oct 4 . . . Now if we get approval for both days, we can even set up a 36 hole two day tournament . . . Please let us know how you feel . . . And we need to hustle to get enough prizes for all participants, if we can . . .

HEPA physician and Soccer Doctor of Honolulu, **Leo Crowley** will leave to take over as director of sports medicines for Saudi Arabia . . . *Star Bulletin* columnist Dave Donnelly feels that Leo will have the Arabs playing soccer in the sand dunes . . . *Advertiser* sports writer Dan McGuire quotes: "May the roads rise with him and the winds be always at his back" (Whatever it means). Leo is credited with nurturing amateur youth soccer in Hawaii over the 7 years he spent here. He will be responsible for Saudi's national teams in track and field, swimming and basketball . . . but no mention of soccer . . .

Advertiser Sports writer Dan McGuire calls **David Eith** "a baseball addict" and recalls: "Dr. Eith, for the uninitiated, is the Honolulu physician who traveled to New York City several years ago when Yankee Stadium was being rebuilt. He purchased at auction, two dilapidated pieces of furniture that had served as box seats since the stadium opened in the 1920's. The good doctor, clutching the chairs as if they were as valuable as the Hope diamond, took a subway train back to his hotel in Manhattan. His fellow passengers were so staggered by this unusual sight there were no muggings or other untoward incidents. Then he nursed them aboard a United 747 for the flight home to the Islands where they now repose in his Kahala residence after public exposure."

Hors de Combat

Joel Hirsch, an LA optometrist was in town describing "orthokeratology" which costs $1800 and involves 2 years of treatment, wherein a series of 14 pairs of contact lenses apply pressure to the cornea to change its shape, thereby bringing back vision to 20/20 in cases of astigmatism, near sightedness and far sightedness. Hirsch gets 90% success rate but accepts only 50% of those seeking treatment.

The DOH (Department of Health) is having its hospital problems . . . Kona Hospital with its 47 beds and 4 extended care beds had to transfer some extended care patients because of an acute shortage of acute care beds. An extended care ward on its first floor remains closed due to a lack of skilled nurses . . . Next was Hilo Hospital . . . Medical director **Kenneth Hughes** resigned a month earlier and accused the DOH of negligence in its administration of the hospital system. "Many of the problems in our hospital system are symptoms of a nonfunctioning administration . . . There are a number of bad things coming to a head and the administration is not really close enough to the hospital to maintain the necessary level of quality care."

Then along came MMH . . . The Maui Memorial Hospital's staff is reportedly on "the verge of breakdown from overwork and a dangerous situation exists on a ward that mixes the acutely ill children with old patients and psychiatric care patients . . ."

On Dec 19, **Russell Stodd,** president of Maui County Medical Association testified before a Senate fact finding committee investigating conditions at MMH: "It is time to give serious consideration to removing MMH from the DOH. We must have local accountability: local, autonomous and empowered to act." Incoming chief of staff **William Kepler** alleged that he had been ignored repeatedly by the State administration and felt that pediatrics, psychiatry, geriatrics, ICU, CCU and medical social work are areas of concern. **Sakae Uehara** told the group, "Patching, patching, patching will result in disaster. A new tire is needed." Outgoing chief of staff **John Withers** advocated "returning administration and fiscal control to the county, administered by a local board with proper staff, equipment, set rates and standards."

Undersecretary of HEW, Hale Champion, told a House Subcommittee that the government will begin paying for 2nd medical opinions for patients facing elective surgery under Medicare. The House Interstate and Foreign Commerce subcommittee had reported in Jan 1976 that 2.4 million unnecessary operations were performed in 1974. Champion testified that the overall rate of surgery increased by 22% between 1970 and 1975 with the rate of hysterectomies increasing by 34% and herniorrhaphies by 53%. The overall rate of surgery is 31% higher in the Midwest than in the South. He also testified blatantly that "there are many thousands more surgeons than we need and the number of surgeons trained at taxpayer expense must be cut back."

Advertiser columnist George Daacon writes: "Did you know that Hawaii only has 16 plastic surgeons? I didn't either till I met Dr Gunther Hintz, a new arrival on the scene, who claims Hawaii is a wide open market for attracting the type of clientele who normally zip to Miami, Rio, or even Europe for a face lift. 'Hawaii should be promoted as the perfect place to have such reconstructive surgery performed," says Gunther, obviously hoping to cash in on the biz."

Internal Medicine Workshops

The UH Integrated Medical Residency program has started a unique and enjoyable lecture series once monthly from 5 to 7 pm Wednesdays, replete with drinks, pizza and dialogue . . . The charge is 2¢ per xeroxed page of reference material and a nominal charge for refreshments. The workshops are held in Rm 618 of the University Tower Bld at QMC, next to the Physicians Office Bld with plenty of parking space available . . . Those interested should contact Alvin Furuike, Elsie Wang or Maxwell Rent . . .

Herein are notes from **Gary Glober's** December 14 lecture on "Problems in Liver Disease":

re Chronic Active Hepatitis: Steroid therapy if SGOT is greater than 10 times; Etio: Type B Hepatitis, autoimmune phenomena, drugs eg Aldomet, INH, etc and a/c ulcerative colities, Crohn's and Wilson's Diseases . . .

re Prophylaxis: Give standard immune globulin in both HB and HA . . . Cost of Hepatitis B Immune Globulin is over $200 . . .

re Chronic liver disease: usually from anicteric hepatitis and seldom from acute hepatitis

re Workup: If HBsAg positive, repeat in 4 months; if still positive, then carriers, and follow with liver function tests. When SGOT is 4-5 times normal, then do liver biopsy . . . If HBsAg negative, and SGOT is 4-5 times, then repeat in 6 months. If still elevated, then biopsy . . .

re Chronic Active Hepatitis: with HBsAg positive, treat with prednisone 30mg/d. Never give steroids in acute hepatitis.

re Chronic Portal Systemic Encephalopathy: Etio: hypokalemia, alkalosis, subclinical infection; Drug action: Librium, Valium and demerol have increased ½ life except for Serax . . .

Management: Both Lactulose and Neomycin effective

re Hepato-renal Syndrome: pressure phenomenon rather than volume phenomenon . . .

Levine peritoneovenous shunt: reverses urinary Na excretion

Swantz Ganz catheter: indicated for measuring cardiac output and pulmonary pressures.

Ascites: Use Sprinolactone

Treatment: Steroids and/or Imuran for 1 year . . .

"The liver is a vicious and depraved organ" . . . (Gary warns)

The following notes are from **Robert Morrison's** lecture on Jan 11 "Treatment of Edema":

re Mercuhydrin IM: Since it was intermittent Rx, there were seldom difficulties since "the body tends to protect itself" . . . With the advent of thiazides, women with cyclic edema

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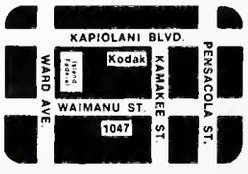
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a/c menses became addicted to diuretics . . . and got into trouble . . .

re Thiazides: The complications started with the 7 day a week continuous therapy instead of intermittent Rx as with Mercuhydrin . . .

re Hypokalemia: Formerly, we treated with large red potassium pills which came out as large white pills and notched pills still came out with the notches . . . Then we turned to liquid suspensions which gave GI symptoms . . . So this led to K gluconate, K citrate, K acetate pills with less GI effects . . . But then the kidney couldn't absorb K± without Cl− as when the patient is on a low salt diet. There are no foods with Cl− so they need KCl . . .

re Thiazides vs Spironolactone: Thiazides cause water excretion with K depletion whereas Spironolactone has small water excretion and thus K retention or elevation . . . Do not give K supplements with Spironolactone and Dyrenium . . . K intoxication is perhaps one of the commonest causes of death . . .

re Glucocorticoids: Methyl prednisolone etc cause water diuresis . . . They move water out of joints (eg in RA) and from the brain . . .

re Furosemide and Ethacrinic Acid: Increasing the dosage causes greater diuresis . . . Therefore good for patients with poor renal function . . .

re Furosemide: It is a 4 hour diuretic so if no effect with 40 mg, then double the dose. Keep increasing the dosage . . . No patient can be resistant to increased dosages . . .

re Hyperkalemic deaths: deaths are usually caused by cardiac arrhythmia. Since the normal K level in postmortem is 17 or 18 meq, no way to prove hyperkalemic deaths . . . Should be a good way to commit murder with no way to trace . . .

"The combination of Spironolactone and hydrochlorothiazide is the greatest Na excreter . . ."

"The single agent most potent is Mercuhydrin . . ."

Miscellany

Three buddies from Hawaii, a buddha head, a haole and a porogee were driving cross country and somehow got lost in farm country with no motels in sight . . . It was getting dark and they stopped at a small farm house to ask for shelter for the night . . . The friendly farmer had beds for only two, but suggested that one could be comfortable in the barn . . . The buddha head volunteered and went out to the barn . . . but soon there was a knock on the door and there was the buddha head. "Looks as though I'm allergic to pigs . . . My asthma is acting up . . ." The haole went next because he wasn't allergic to pigs . . . Again there was a knock on the door and there was the haole saying, "I can't stop sneezing . . . I must be allergic to cows . . ." The porogee went confidently: "Don't worry, I'm not allergic to pigs or cows . . ." But soon there came a knock on the farm door again . . . And there stood a pig and a cow grunting and snorting furiously . . . (As told by the MC at dentist **Ken Ozaki's** surprise 60th birthday . . .)

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WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed, Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,0 Persons When States Adopt Cooperating Laws–He the Measure 'Cornerstone' of His Economic Progr

WASHINGTON, Aug. 1 The Social Security Bill, p a broad program of unemp insurance and old age and counted upon to bene 20,000,000 persons, becam day when it was signed b dent Roosevelt in the pre those chiefly responsible ting it through Co[illegible]s.

Mr. Roosevelt cal[illegible] "the cor[illegible]erstone whi[illegible]s being [illegible] me[illegible]s comple[illegible] rin[illegible] to [illegible]

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today 94 to 0 and sent to

TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

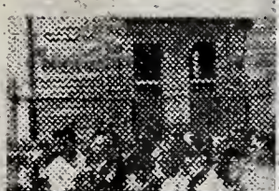
The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGNI the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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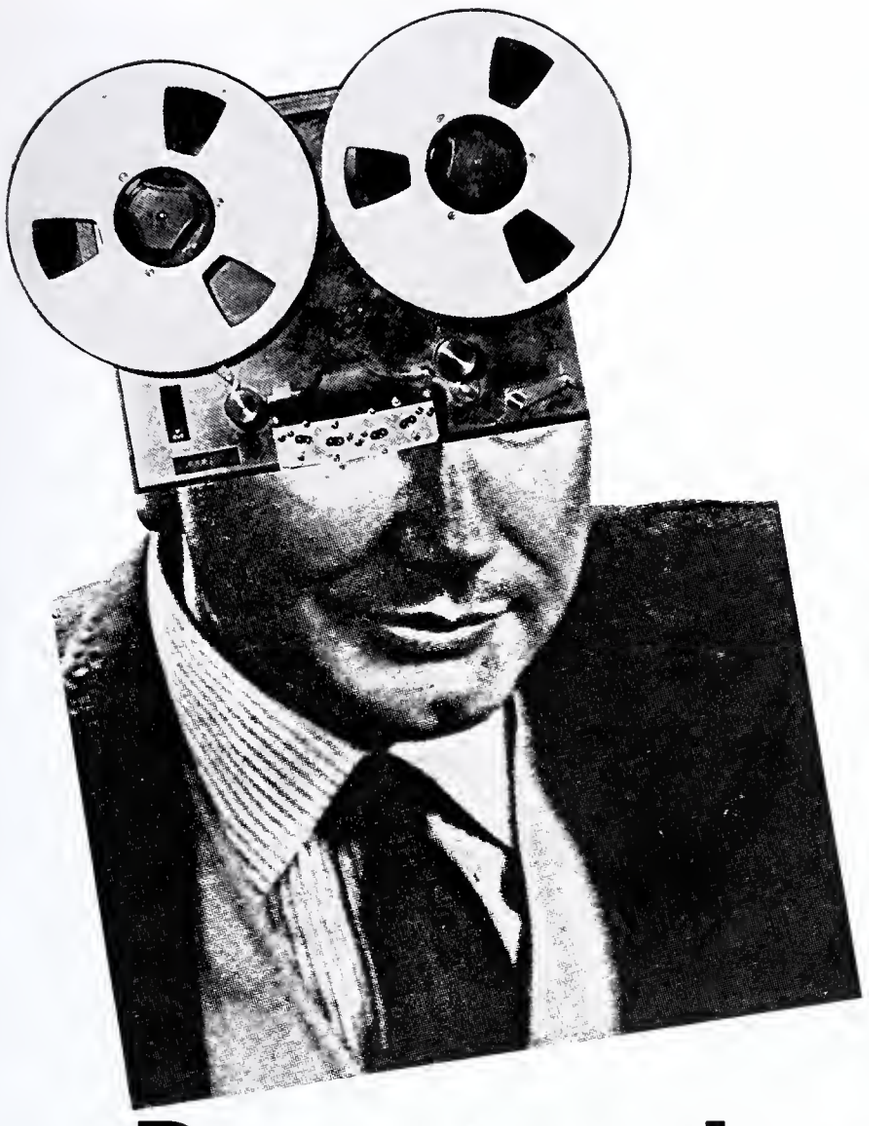


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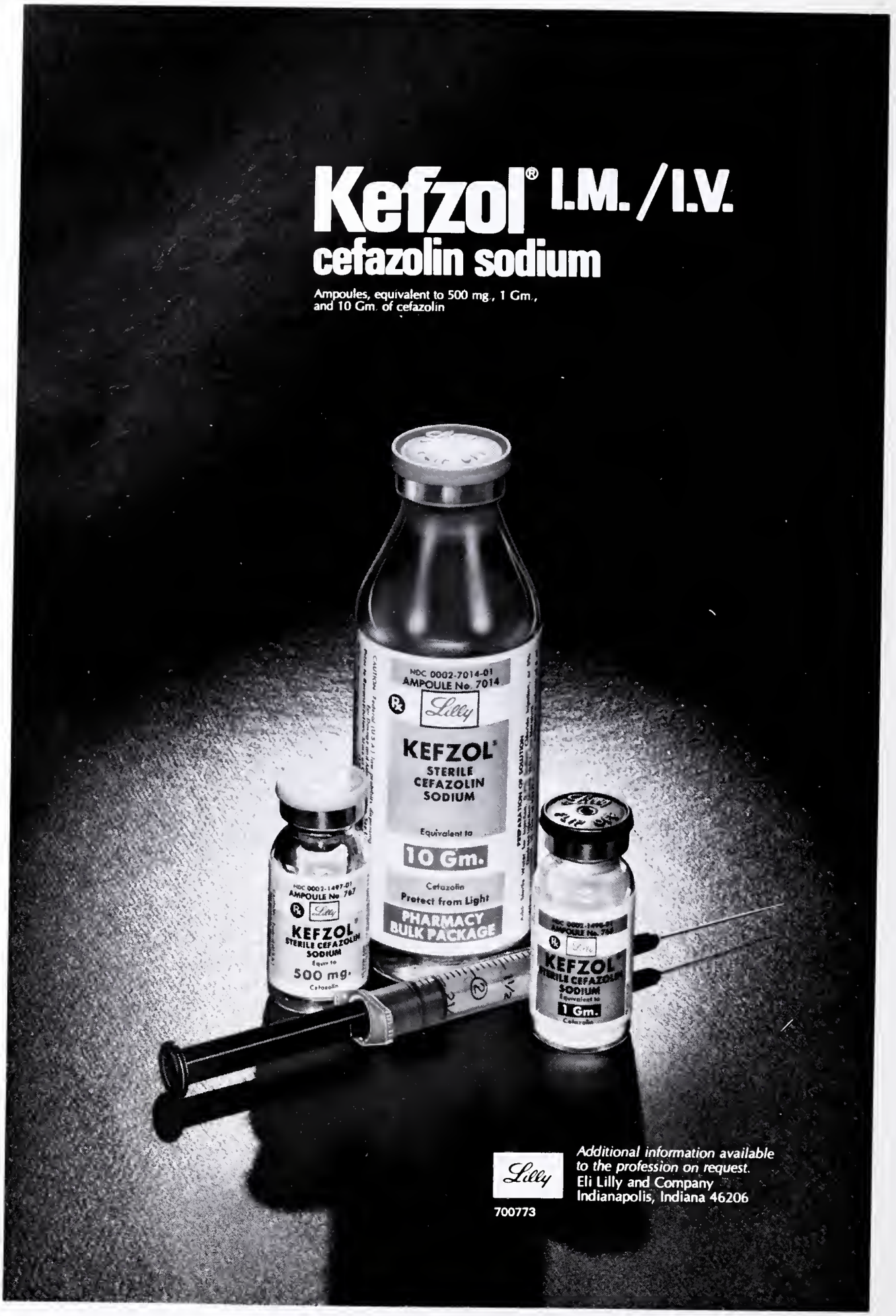
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Hawaii Physicians' Attitudes and Practices Regarding Reproductive Health Services for Minors

Jeanne H. Fertel, Ph.D., M.P.H. *and* Roy G. Smith, M.D., M.P.H., *Honolulu*

• *With teenage pregnancies reaching epidemic proportions in the United States*[1] *and with a sharp increase in venereal disease among adolescents, many health professionals are urging legislators to focus more attention on laws that can assure better reproductive health care for sexually active minors.*

Legislative Background

Hawaii has no law specifically requiring parental consent for a minor to receive contraceptive services. Under the common law, minors, along with the mentally deficient and insane, are considered incapable of giving effective consent for medical treatment. Thus, parental consent has been required as a substitute for the minor's consent; physicians treating minors without parental consent face the possibility of a civil suit by the parents for damages. However, there are no cases reported as yet of a doctor being held liable for prescribing a contraceptive to a minor without parental permission.[2]

In 1968, the Hawaii Legislature enacted a law enabling minors over the age of 14 to consent to "care related to pregnancy." This law specifically excluded surgery and abortion from the category of pregnancy-related care for which a minor could give consent. In addition, it required that a physician, performing a pregnancy test for a minor, must inform her parents if the results are positive, even if the patient should object. In 1975, the Legislature enacted a law enabling minors to give consent for the treatment of venereal disease. This latter law provides that the physician may use his discretion in deciding whether or not to notify the patient's parents.[3]

The issues surrounding the provision of contraceptive care and abortion services for minors have been raised in the Hawaii Legislature for the past several years. In every session since 1967, bills have been introduced to enable minors to obtain contraceptives without securing parental consent, and to remove the requirement that a physician notify a minor's parents when he diagnoses her pregnancy. These bills have aroused considerable controversy, and none has ever passed. At the close of the 1975 session, the House of Representatives adopted a resolution "Requesting the Legislative Reference Bureau to Conduct a Study on the Rights of Minors" including "the minor's right to health services with specific reference to provision of gynecologic, contraceptive, and abortifacient services . . ." (HR-717). As part of this study, the authors, under the auspices of the Legislative Reference Bureau and the Hawaii Medical Association, conducted a survey of Hawaii physicians' views and practices relating to the provision of contraception and abortion services for minors.*

HMA Members Polled

Questionnaires were mailed to all 485 practicing obstetrician/gynecologists, internists, general or family practitioners, and pediatricians who were members of the Hawaii Medical Association. Of the 246 who replied, 161 gave the location of their principal office as being in Honolulu, 37 in suburban Oahu, 22 on Maui, 17 on Hawaii, 6 on Kauai, and 3 in rural Oahu or on other islands.

*Since this survey was completed, there have been the following legal developments:

—On May 21, 1976, the Governor signed into law a bill enacted by the Hawaii Legislature emancipating married minors and enabling them to give consent for medical care.[4]

—On May 24, 1976, the United States Supreme Court ruled that sexually active minors who are Medicaid-eligible may not be required to obtain parental consent in order to receive contraceptive services funded under the Medicaid program.[5]

—On July 1, 1976, the U.S. Supreme Court ruled that parents may not be given a veto power over their minor daughter's abortion.[6]

—On April 13, 1977, H.B. 1097 that would allow contraceptive care for minors without parental consent was killed in the Hawaii Senate Judiciary Committee.

—On June 9, 1977, the U.S. Supreme Court ruled that minors have a Constitutional right of access to contraceptives. It did not, however, rule on the question of parental consent.[7]

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TABLE 1.—*Number and percent of physicians providing selected services to minors*

SERVICES	NUMBER OF PHYSICIANS	PERCENT
Contraceptives prescribed or dispensed:		
with parental consent only	24	9.8
without parental consent	106	43.1
never	111	45.1
response regarding parental consent	5	2.0
TOTAL	246	100.0
Abortions performed in office:		
with parental consent	10	4.1
without parental consent	2	0.8
never	234	95.1
TOTAL	246	100.0
When pregnancy tests positive, notify parents:		
with consent of patient	13	5.3
without consent of patient	44	17.9
only if patient requests	79	32.1
does not notify—patients given responsibility	32	13.0
did not provide pregnancy tests	78	31.7
TOTAL	246	100.0

Questions were asked about the physicians' practices regarding pregnancy tests, contraceptives, and office abortions for minors. The replies are summarized in Table 1.

Of the physicians responding, 168 reported having performed pregnancy tests for minors during the year past. Of these, 44 (26%) said they notified the patient's parents themselves if the result was positive. Also, 13 (8%) said that they notified the patient's parents, but specified that they first discussed it with the patient and obtained her consent. Of those physicians providing pregnancy tests, 79 (47%) reported that they did not notify the parents, unless the pregnant minor patient requested that they do so. An additional 32 (19%) physicians reported that they advised their patient to notify her parents. In sum, when faced with a minor patient whose pregnancy test is positive, 57 of the physicians, or approximately one-third of those providing pregnancy tests, would personally notify her parents, sometimes only after talking to the patient and persuading her to give consent. Approximately two-thirds (111) did not routinely notify the parents or gave the minor the responsibility of notifying her parents. An additional 78 (32%) of those responding provided no pregnancy tests to minors.

The number of physicians reporting that they had prescribed contraceptives for minors during the past year totaled 135. Of these, 24 (18%) said that they did so only with the parent's permission. Another 106 (79%) did so at least occasionally without parental consent. Five physicians (4%) did not specify whether or not they required parental consent.

Of the responding physicians, 12 reported having performed endometrial aspirations or other types of abortion procedures on minors in their offices. Of these, 10 always obtained consent from the patient's parents and 2 did not.

Influence of Specialty, Experience, Office Location

Among physicians practicing in Honolulu, the obstetrician-gynecologists reported themselves the most liberal in their practices. Of those who reported prescribing contraceptives for minors, 82.1% did not require parental consent. Of those who performed pregnancy tests for minors, 81% did not inform the patient's parents of a positive result. Progressively more conservative are pediatricians, internists, and general practitioners. Among the GP's, 62.5% prescribing contraceptives to minors did not require parental consent.

The obstetrician/gynecologists see by far the majority of the minor patients for reproduction-related problems in Honolulu. Only 3 or 4 members of each of the other specialties reported receiving more than 5 requests from minors for some kind of reproductive health service during the year. In general, the 187 (76%) physicians who had received requests from minors for some form of treatment were more liberal in their attitudes than were the 59 (24%) physicians who had not. It is not clear whether this occurs because minors wanting treatment seek out physicians who have liberal reputations, or because those physicians who are repeatedly confronted with minors in need of care become more liberal in their attitudes. Some indication that the latter explanation may be the correct one can be seen in the data from suburban Oahu and the neighbor islands. Since there are very few obstetrician/gynecologists practicing in these places, most patients are seen by general practitioners. These GPs appear to be more liberal in their practices than are those in Honolulu. Of the physicians in suburban Oahu who prescribed contraceptives for minors, 16 (80%) did so without requiring parental consent.

The corresponding figures for the other islands are Maui—100% (14), Hawaii—83.3% (10), and Kauai—50% (2).

Liability Concern

The reason most commonly given by reponding physicians for refusal or reluctance to treat minors is fear of being prosecuted or sued, particularly if complications develop. Typical of these reactions was the comment of a Kauai family practitioner: "I worry about legal liability every time a minor comes in . . . For contraception for minors under age, I have option of referring to Hawaii Planned Parenthood, which is less afraid of treating them . . . I am scared to do an abortion without parental consent until the law is changed."

Some physicians are willing to prescribe medication but require parental consent for surgical procedures. Sometimes the definition of surgical procedure can extend rather far. Several physicians remarked that they prescribe pills to minors without parental consent, but will not insert an IUD because they consider IUD insertion a surgical or invasive procedure.

A few physicians attempt to avoid the whole problem by carefully neglecting to ask their patients' ages. It has also been reported to the authors that some advise minors wanting abortions to lie about their age when being admitted to the hospital.

The second most common concern expressed by the respondents was fear of not being paid. Although we had specifically asked them not to consider the factor of financial responsibility, many physicians were apparently unable to separate the issues of consent and payment.

A smaller number of physicians than in either of the above categories said that they refuse to treat minors because they support the right of parents to control their children. Typical of this attitude is a comment by a Honolulu internist: "I feel strongly that the legal guardian or parent of any minor deserves to know the fact of pregnancy, need for abortion, and/or need for contraception, regardless of how smart or reasonable the minor happens to be."

An equal number of physicians doubted that consent requirements really serve any true interests of parents. A Honolulu obstetrician/gynecologist said: "In actuality, parents have very little influence on their daughter's sexual activity. They cannot stop sexual activity by refusing to consent to birth control counselling." Others pointed out that no one asks for parental consent to have sex, and that "most teenagers are not in the habit of discussing their sex lives with their parents."

Some parents want their daughters to be protected from pregnancy, but do not want to know about their activities. Two physicians mentioned that several of their patients had left written "standing orders" that if their daughters came in asking for contraceptives, the doctor should provide them and should not notify the parents.

A few physicians expressed misgivings and ambivalence about teenage sexual activity in general, and about their possibly encouraging it by providing the teenagers with reproductive health and medical care. Two specifically mentioned that they will not prescribe contraceptives unless it is evident that the minor is already sexually active.

Regarding the requirement that parents be notified of a minor daughter's positive pregnancy test, several physicians felt that this involved them in an ethical conflict of interest with respect to doctor-patient confidentiality. A Honolulu obstetrician/gynecologist pointed out that practical problems also arise: "Many minor patients use false names and addresses so that notification of their parents is impossible."

Several physicians expressed the opinion that parental consent or notification requirements for abortion cause many girls to postpone their abortions until the second trimester, due to fear of confronting their parents. However, one doctor has a different view of these girls' motivation. He feels that many of them really want to have their babies and so delay, hoping that by the time their parents find out they are pregnant it will be too late for an abortion.

Conclusion

Many Hawaii physicians are providing minors with reproductive health care. More would like to, but are concerned about the legal situation. Judging from the incidence of unplanned and unwanted teenage pregnancies and venereal disease as well as data from this study, many minors are not receiving needed reproduction-related preventive, supportive and counseling services. For these essential services to be available from the majority of physicians, Hawaii will probably have to follow the example already set by 26 states and the District of Columbia,[8] and enact legislation that specifically protects the physician who provides reproductive health services to minors without parental consent.

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Where do Oahu's young parents seek help?

Young Parenthood in Hawaii

MARGARET JOAN WOOTTON, R.N., M.P.H., *and*
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• *Comprehensive programs, encompassing medical, social, and educational services, have been shown to reduce the risks of young parenthood (1), and are strongly recommended by both the National Alliance Concerned with School-Age Parents and the Consortium on Early Childbearing and Childrearing (2). While Hawaii does not have such a comprehensive service program, individual service components are offered by various public and voluntary agencies. Operating independently, these agencies lack a standard data collection system to describe young parents and the services needed by and rendered to them. Although it has been apparent that many young parents in need of services were not receiving them, it has not been known which young parents were being served, what services they were receiving, when and from how many agencies they were seeking and receiving services, and where major service gaps existed.*

A survey to determine the service utilization pattern by young expectant parents on Oahu was proposed by the study group of the Young Mother's Committee, Social Services Department, Health and Community Services Council of Hawaii. A summary of survey findings is reported herein.

Methodology

The survey was a retrospective study of 93 of 100 teenage mothers who were keeping their infants. (An additional 5 teenage mothers delivered and gave their babies up for adoption.) They delivered in 3 major civilian obstetrical units on Oahu between mid-June and mid-September 1976. Interviews with the mothers were conducted on the postpartum ward, using a pretested interview schedule, after signed informed consent had been obtained. Descriptive data about the majority of the fathers were also obtained during the mothers' interview. Additional information was collected from 26 fathers who completed a short self-administered questionnaire.

The 7 non-participant mothers did not appear to differ markedly from the sample in ethnicity, age or marital status. Although the time period of the study was limited, and a fourth major obstetrical unit could not be included, the survey population is considered to be representative of a larger population of teenage mothers. There was little difference in proportions of ethnic groups (Table 1) and age (Table 2) found between the survey population and Department of Health data for teenage mothers delivering in the 4 hospitals between January 1 and June 30, 1976.

Characteristics of Young Parents

The youngest mother in the sample celebrated her 15th birthday one day postpartum, and the oldest mother turned 20 a few days later. Mothers who were minors numbered 37. The ages reported for 77 of the fathers ranged from 15 years to the mid-40s, with 31 fathers known to be teenagers, including 10 minors. The next largest group of fathers was between 20 and 24 years of age. These young fathers could be expected to be in need of financial, educational and vocational services. Part-Hawaiian fathers, the largest ethnic group, tended to be relatively youthful, while Filipino fathers tended to be older.

Of the teenage mothers, 49 were single and 44 were married at the time of birth of their infants. None of the 15- or 16-year-old mothers was married. The difference in the marital status of the minor and adult mothers in the study is statistically significant (Chi square p:<.01). The relationship of the fathers' age and marital status was similar to that of the mothers', the majority of younger fathers being single, the majority of older ones being married. The more youthful marriages resulted in Eleven teenage couples who were married, including two with spouses who were minors. There appeared to be a trend for part-Hawaiian parents to remain single and for Filipino parents to marry.

Four mothers had completed grade 8 or less; 40, grades 9-11; 42, grade 12; and 6, a year or more of college. The categories considered for analysis were "less than high school graduation"

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TABLE 1.—*Number and per cent of teenage mothers by ethnic group in survey and in prior six month period*

ETHNIC GROUP	SURVEY		DEPT. OF HEALTH DATA JANUARY - JUNE 1976	
	NUMBER	PER CENT	NUMBER	PER CENT
Hawaiian/part Hawaiian	45	48.5%	246	44.8%
Caucasian	15	16.1%	86	15.7%
Japanese	5	5.4%	53	9.6%
Filipino	11	11.8%	116	21.1%
Other	17	18.3%	48	8.7%
TOTAL	93	100%	549	100%

TABLE 2.—*Number and per cent of teenage mothers by age in years in survey and in prior six month period*

AGE IN YEARS	SURVEY		DEPT. OF HEALTH DATA JANUARY - JUNE 1976	
	NUMBER	PER CENT	NUMBER	PER CENT
13 years	—	—	1	0.2%
14 years	—	—	3	0.5%
15 years	5	5.4%	17	3.0%
16 years	8	8.6%	52	9.5%
17 years	24	25.8%	92	16.8%
18 years	28	30.1%	168	30.6%
19 years	28	30.1%	216	39.4%
TOTAL	93	100%	549	100%

and "high school graduation or more." Of the 71 fathers for whom educational status was established, 26 had not completed high school.

Primiparas totaled 76; 14 had delivered one previous child, and 2 had delivered 2 previous children.

The young parents in this study gave birth to 6 premature infants. The 2 smallest infants (2 lb. 14 oz. and 4 lb. 4½ oz.) were born to mothers who had had one previous child, and the third smallest was born to a 15-year-old mother.

Major Problems of Young Parents

The young parents were given a list of social and psychological problems, and asked if any, none, or others, were problems for them. They were then asked to rank the 4 major problems in order of importance. Young mothers reporting at least one problem numbered 65, while 13 reported 4 or more. The ranked list of problems and responses is presented in Table 3. Finances emerged as the biggest difficulty, with 27 mothers reporting it as most important and another 10 reporting it as their second or third most important. Education, housing, parents' reaction, and employment, respectively, were the 4 next most important problems for the teenage mothers. Finances was given as the most major problem for the 26 fathers who responded to this question. It was followed in importance by housing, employment and then education.

The mothers' major sources of support were social agency, husband, parents' assistance and multiple sources. Only one mother was self-supporting. The majority of mothers expected to have the same support sources during the 6 months following delivery. When change was anticipated, it was usually away from parental and multiple sources toward increased reliance on the baby's father or a social agency.

The majority of mothers lived with their parents and/or the baby's father during pregnancy and expected to continue to do so in the next 6 months. When change was anticipated it was again away from parents and towards the baby's father. Two mothers lived alone during most of their pregnancy and 2 stayed in a residential home for young mothers.

Education had been interrupted for 16 of the 37 minors. Mothers who had dropped out of school before becoming pregnant totaled 14. Less than half the mothers who wished to continue their education had discussed their goals with a school counselor or social worker. Two mothers would have attended a special school for pregnant girls had they known about one. One had dropped out of school before her pregnancy; the other had dropped out at 3 months of pregnancy in order to conceal her condition. She did not wish to discuss her pregnancy with anyone at school and was unaware of public health nursing services outside the school system.

Very few young mothers were employed and most were unskilled. Over half of the fathers were also unskilled.

Young Parents' Sources of Health Services

Visiting a private physician for their pregnancy test or diagnosis were 67 mothers. One had had no physician or agency contact for diagnosis of her pregnancy and went directly to a hospital in labor. The remaining 25 went to vari-

TABLE 3.—*Mothers' problems, ranked in order of importance*

PROBLEM	ORDER OF IMPORTANCE #1 NO.	#1 %	#2 NO.	#3 NO.	#4 NO.	TOTAL NO.	TOTAL %	WEIGHTED VALUE X	RANK
Finances	27	42.2	9	1	—	37	57.8	137	1
Education	7	10.9	6	5	1	19	29.7	57	2
Housing	7	10.9	6	3	—	16	25.0	52	3
Employment	5	7.8	1	3	3	12	12.9	31	5
Parents' reaction	4	6.3	4	3	1	12	12.9	35	4
Finding a babysitter	2	3.1	—	—	1	3	4.7	9	9
Loneliness	2	3.1	1	1	—	4	6.3	13	8
Caring for Child	2	3.1	4	—	—	6	9.3	20	6
Depression	2	3.1	2	—	1	5	7.8	15	7
Marriage relationship	1	1.6	1	—	—	2	3.1	7	10
Relationship with baby's father, if not husband	1	1.6	—	2	1	4	6.3	9	9
Others' reaction	1	1.6	—	1	3	5	7.8	9	9
Loss of freedom	—	—	—	2	1	3	4.7	5	11
Self-image	—	—	1	—	—	1	1.6	3	12
Other	3*	4.7	—		1**	4	6.3	13	8
TOTAL	64	100.0	35	21	13	—	100.0	—	—

*Baby's health (B W 5-12)
—"grouchy" during pregnancy at times
—tearful throughout pregnancy, "I cried for no reason even when my husband was nice to me"
**relationship with boy friend (father's identity unknown)

Total no. responding: 93
no. reporting problems: 64
no. reporting "no problems": 29

x—weighted value
#1: ×4
#2: ×3
#3: ×2
#4: ×1

ous agencies for a pregnancy test. Some mothers remarked that they had not known about free pregnancy tests and would have benefited from the service, having delayed initiation of prenatal care until certain of pregnancy. Seven mothers waited a month or more after confirmation of their pregnancy at an agency to obtain prenatal care. One mother with an uncertain test result never sought medical care.

Although the timing of initiation of prenatal care for the young mothers in this study is similar to that of all mothers in the state in 1974, there is nevertheless some concern for this particularly high-risk group. Optimally, all young mothers would have their first prenatal examination in the first trimester of pregnancy. There were significant differences in marital status, age and educational level among those mothers who initiated their prenatal care in the first trimester, compared with those mothers who initiated it later or not at all. Mothers who were married, adult, or attained high school graduation or more, were significantly more likely to have their first prenatal visit in the first trimester than were single minors with less than high school education (Table 4). Lack of funds and up to a 3-month wait for medical coverage from the Department of Social Services and Housing were given as reasons by some mothers for delay past the second trimester of pregnancy. One 18-year-old

TABLE 4.—*Characteristics of mothers and initiation of prenatal care by trimester*

CHARACTERISTIC	NUMBER OF MOTHERS INITIATING CARE, BY TRIMESTER FIRST*	SECOND	THIRD	NO CARE	TOTAL
Marital status					
Single	26	17	4	2	49
Married	35	9	—	—	44
*Chi square p:<.025					
Education					
Less than high school	21	19	2	2	44
High school graduation	39	7	2	—	48
*Chi square p:<.01					
Age					
Minor	20	15	2	—	37
Adult	41	11	2	2	56
*Chi square p:<.05					
TOTAL	61	26	4	2	93

TABLE 5.—*Mothers' sources of information on family health topics*

TOPICS	SOURCES OF INFORMATION							
	SCHOOL	PHN	MD	PRENATAL CLASS	MIC*	FPC OR HPP**	MEDIA	OTHER***
Birth control	36	—	30	2	3	21	21	31
Sexuality	52	1	1	—	—	1	7	18
Venereal disease	66	—	3	—	—	3	16	11
Pregnancy	48	1	44	16	3	7	32	31
Abortion	41	—	8	1	1	6	32	19
Marriage	31	—	1	—	—	—	9	35
Prenatal exercises	4	—	16	21	6	1	19	6
Labor and delivery	8	1	30	24	6	—	26	19
Nutrition in pregnancy	5	1	45	14	6	—	30	11
Child care	15	2	27	14	5	—	35	29
Child growth and development	15	1	20	7	5	—	38	21

*Maternal and infant care project **Family planning clinic; Hawaii Planned Parenthood ***Parents, own experience, friends, relatives

denied knowledge of her pregnancy until she was diagnosed at 8 months, when she went to her physician for investigation of "abdominal pains."

A small minority of mothers discussed their pregnancy with their school counselor or school or public health nurse. Almost half of these who did see one of them were referred on to other sources of help. Very favorable remarks were made about special counselling programs. For example, one young mother said that all schools should have a Quick Kokua program, and another praised a worker at the Waianae Rap Center who was always available to help her when she was depressed.

A maximum of 4 major sources of information on each of 11 specific family health topics was recorded (Table 5). School was the most frequently mentioned source of information on venereal disease, abortion and marriage. The physician was a close second to schools as a source of information about birth control and pregnancy, and was the most frequent source of information on labor, delivery, and nutrition during pregnancy.

Not all young parents had received information on each topic, and some reported that their only source of information on certain topics was limited to their own experience, parents, other relatives, or friends (Table 6). Those parents who had not received any information on nutrition in pregnancy also had not received any on labor and delivery or prenatal exercises, and those without information on child growth and development also had none on child care. Many young parents were unaware of the availability of prenatal and parenting classes, such as those offered by the Red Cross and YWCA's Young Mothers' Program.

Neither the quantity nor quality of information received is measured by this study, but the data presented suggest that gaps in young parents' knowledge of important family health topics do exist. In addition, many mothers who indicated an information source commented that they had not received enough information on the topic in question. This response was most frequent in relation to labor and delivery, prenatal exercises, child care and child growth and development.

Prenatal classes are a major community resource offering information that young mothers desire to learn. They are given in several communities in different settings, including at all 3 hospitals in which these mothers delivered. Only

TABLE 6.—*Parents receiving no or limited information on family health topics*

TOPIC	RECEIPT OF INFORMATION MOTHERS (N=93)				FATHERS (N=25)
	NO INFORMATION		ONLY SOURCE: "OTHER"*		NO INFO
	NUMBER	PER CENT	NUMBER	PER CENT	NUMBER
Birth control	6	6.5%	16	17.2%	11
Sexuality	24	25.8%	12	12.9%	8
Venereal disease	11	11.8%	6	6.5%	5
Pregnancy	2	2.2%	1	8.6%	6
Abortion	11	11.8%	11	11.8%	10
Marriage	28	30.1%	30	32.3%	9
Prenatal exercises	38	40.9%	6	6.5%	12
Labor and delivery	12	12.9%	11	11.8%	10
Nutrition in pregnancy	12	12.9%	7	7.5%	15
Child care	7	7.5%	18	19.4%	10
Child growth and development	13	14.0%	16	17.2%	10

*usually parents, own experience, friends, relatives.

25 actually attended prenatal classes. A major reason for non-attendance was lack of awareness of the existence of classes. Other reasons included transportation difficulties, cost, and lack of interest at the time. Most mothers who did attend spoke very positively of the classes and of their birth experience. Knowledge of and control over what was happening to them or desire to have the father present at the delivery appear to be motivating forces for attendance.

Prenatal class attendance was cross-tabulated by marital status, age, ethnicity, area of residence, and educational level. Of 44 married mothers, 14 attended classes, and 11 of 49 single mothers attended. There may be a trend for married teenage mothers to attend prenatal classes more often than single teenage mothers, but the difference is not statistically significant. There was no difference between age groups, with 10 of the 37 minors and 15 of the 56 adults attending.

Analysis of attendance by ethnic group is limited by the small number of mothers in some categories, but there appears to be an attendance pattern. Caucasians had the largest proportion attending (6 of 15) mothers, and Filipinos the smallest. The only member of the latter group attending classes was the one 15-year-old. None of the other 10 Filipino mothers, all of whom were married, attended prenatal classes, an exception to the marital status trend noted above. Six of 11 mothers in the "other" category, 11 of 45 part-Hawaiians, and one of 5 Japanese mothers attended prenatal classes.

The pattern of mothers' attendance also varied by area of residence, but again the numbers are too small for statistical analysis. However, it appears that the highest proportions attending lived in leeward Oahu, central Honolulu, and east Honolulu, while the lowest proportions were the mothers in north Honolulu, central Oahu, and the Waianae coast. The proportion of mothers attending increased with educational level. That more mothers with at least high school graduation attended classes than did those with less than high school graduation is statistically significant. Only 7 of 44 mothers with less than high school education attended prenatal classes, while 18 of 48 mothers with high school education or more did so.

Mothers' Contact With Agencies

Agency contacts had been made by the 93 mothers in 26 cases, prior to their recent pregnancy. Of these, 21 were to the Department of Social Services and Housing. The contacts were not always direct; sometimes the girls' parents received family financial assistance. Some, but not all, of these contacts were maintained during pregnancy.

Young mothers in contact with at least one agency during pregnancy totaled 60. A second agency was contacted by 14, and a third agency by 4 (Table 7), a total of 78 agency contacts. Initial contacts were to the Department of Social Services and Housing in 50 instances and 7 additional second or third contacts were to that agency. The service received from the DSSH was, financial assistance only in 27 cases. Rejected due to ineligibility were 11 mothers, based either on their income or, more often, on the fact that they were minors living with their parents. The majority of applicants saw only a financial worker and not a social worker for counseling. Each of the other agencies were contacted by 4 or fewer young mothers.

The majority of the mothers' referrals to agencies were made either by the girls themselves or by their parents or other family members. Referrals were made by school personnel in 5 cases, from other voluntary agencies in 4, from Juvenile Court in 3, and from a physician in one.

Young mothers who felt they had needed help but did not contact an agency were 6 in number.

TABLE 7.—*First, second and third agencies contacted by mothers.*

SOCIAL AGENCY CONTACTED	NUMBERS OF MOTHERS MAKING CONTACT AT AGENCIES.			
	FIRST	SECOND	THIRD	TOTAL
Department of Social Services and Housing[a]	50	6	1	57
M.J. Pearson Foundation Emergency Pregnancy Center	3	—	1	4
YWCA Young Mothers' Program	2	—	1	3
Catholic Social Service	1	—	—	1
Queen Lihuokalani Childrens' Center	1	—	—	1
Department of Health[a] (MIC)	1	3	—	4
Booth Services for Young Women (Salvation Army)	1	—	—	1
Child and Family Services	—	2	—	2
Outpatient Department	—	1	1	2
Other*	1	2	—	3
a public	51	11	1	63
b voluntary	9	3	3	15
Total	60	14	4	78

Human Services Center
*Waianae Rap Center
Hawaii Youth Correctional Center

Their reasons for not doing so included lack of knowledge of services, distance from source of help, parental pride, and fear of losing rights.

There was a tendency for younger mothers to contact agencies more often than older mothers; 27 of 37 minors had contacted at least one agency, in contrast to only 33 of 56 adults. The difference was statistically significant for contact with voluntary agencies only. Part-Hawaiian mothers were most likely to contact an agency, and Filipino mothers were least likely to do so. Single mothers contacted public and all agencies significantly more than did married ones (Chi square $p.<.001$). Marital status was a more important variable than was age in this respect. Also, mothers with less than high school education contacted agencies significantly more often than did mothers with high school graduation or more (Chi square $p.<.01$). Thus, mothers contacting agencies were typically single minors who had not completed high school.

Future Plans

Almost two-thirds of the mothers planned to continue their education, in a variety of settings, and one-third of the fathers were known to have further educational plans.

By the time of the interview, 39 of the mothers had discussed the timing of their postpartum check-up with their physicians. Two young mothers expected to have the check-up one week later; 5, 2 weeks later; 15, 4 weeks later, and 17, 6 weeks after delivery. The majority planned to have their check-up at a private physician's office or a Kaiser clinic; 4 at a Maternity and Infant Care clinic; and 3 at a hospital and outpatient clinic. Three mothers did not know where they would have their medical follow-up because their plans were unsettled.

Fifteen mothers said that they were definitely not going to have any more children; 60 mothers wanted more; and 17, mostly single, were undecided. Mothers who wanted to have more children, and 2 who were undecided, indicated how many more they might have. Of 62, 25 said only one more child; 15 said 2 more children; 9 said 3 more; and 13 said 4 or more children. Some added comments such as, "I want as many as we can afford" or "I want only 2 more children but my husband (also a teenager) wants at least 10!" Plans for the next pregnancy were stated by 57 of the group. One mother wanted to conceive in less than 6 months; 3 in 6 to 12 months; one within 18 months; 15 by 2 years; 13 within 3 years; and 24 over 3 years.

Of the total, 13 did not plan to use any method of birth control, and 28 had not yet selected a method. Several expressed fear of possible adverse side effects from "the pill," quoting items they had read in magazines or newspapers or had heard on television. "The pill," however, was the choice of 28 who had selected a method, followed in popularity by the IUD (17), condom (3), diaphragm (1), and withdrawal (1). The young mother was not always the person who chose the method. One girl, who had not received birth control information, said, "We are going to use a condom. My husband chose it." One mother wanted to use an IUD but stated that her husband, through jealousy, would not let a doctor perform the insertion.

The majority of mothers planned to obtain their birth control measures from their private physician or a Kaiser clinic. Other agencies expected to be sources were: Hawaii Planned Parenthood (8), Rural Oahu Family Planning Clinic (4), Maternity and Infant Care Project (4); and Kapiolani Outpatient Clinic (4).

Eighty mothers planned to have their infants immunized, 3 did not wish to, and 8 had not thought about it and had been unaware of the need. The majority with plans to obtain immunization for their infants expected to do so at their private physician's office or Kaiser clinic. The remainder planned to go to a Child Health Conference (6), or other state health department clinic (2). Not knowing where to go for immunization were 6.

Summary and Conclusions

A service utilization study of 93 teenage mothers who delivered their infants in 3 major obstetrical units on Oahu in the summer of 1976 revealed distinct patterns of service use, and identified gaps in services to a high-risk group. The young mothers identified finances, education, housing, parents' reaction to the pregnancy, and employment as their major problems. Not all mothers were aware of availability of free, confidential pregnancy tests, and tended to delay initiation of prenatal care until they were certain of pregnancy and had informed their parents. Mothers who were married, of adult status, or had completed high school sought care significantly more often in the first trimester of pregnancy than did single minors with less than high school education. Those with high school education were also more likely to attend prenatal classes. Conversely, the less educated, single, younger women were more likely to contact social agencies. The Department of Social Services and Housing was the major contact agency for these women, with 57 applying for or receiving assistance from that agency. Often, only the financial needs of the women were attended to, and delays of up to 3 months for medical coverage were encountered. Gaps in knowledge of important family health topics were apparent. Twelve women reported receiving no information on labor and delivery, and many others wished that they had known more about them as well as about birth control, child care, and growth and development. Many were unaware of the availability of prenatal parenting classes, and most expressed interest in them.

The school, the physician and the DSSH were the prime service contacts for the young mothers. However, these services are uncoordinated, and others in the community are not being fully utilized by young parents. Family life education in the elementary and early high school years is recommended to increase potential young parents' knowledge both of family health topics, including the importance of early prenatal care and the risks of early parenthood, and of community services available for birth control, pregnancy tests and counselling. Both physicians and DSSH workers, as initial contact persons, could play key roles in coordination and referral. Physicians could enhance their care of young parents by working as members of an interdisciplinary team, utilizing all resources available to them, thus helping to ensure the best possible physical, emotional, social, and educational support for their young patients.

Acknowledgements

The authors gratefully acknowledge the assistance of Dr. James D. Drorbaugh, Chief of Maternal and Child Health Branch, State Department of Health; and Dr. R. Warwick Armstrong, Dr. Robert M. Worth, and Dr. Roy G. Smith, Professors, School of Public Health, University of Hawaii.

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1 Klerman, L. and Jekel, J. F. *School-Age Mothers: Problems, Programs, and Policy*. Linnet Books, Conn., 1973.

2. Howard, M. and Eddinger, L. Series: *School-Age Parents: a Health Approach, a Social Approach, and an Educational Approach*. Consortium on Early Childbearing and Childrearing, Child Welfare League of America, Inc., Washington D.C., and the National Alliance Concerned with School-Age Parents, Syracuse, N.Y. 1973.



BLEMISHES?

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JON WON

AMA Board of Trustees met on Maui in mid-February for a very serious session on future directions of the AMA. Guests at the Maui County Medical Society membership meeting February 14th were Dr. John Budd, AMA President, and Mrs. Budd; Dr. Tom Nesbitt, AMA President-elect, and Mrs. Nesbitt; Dr. Jim Sammons, AMA Executive Vice-President, and Mrs. Sammons; Dr. Robert Hunter, AMA Chairman of the Board of Trustees, and Mrs. Hunter; and Mr. Joe Miller, Senior Executive Vice-President of the AMA, and Mrs. Miller; and Dr. George Mills, AMA Board member from Hawaii, and Mrs. Mills. MCMS President Russ Stodd did a marvelous job of hosting this meeting.

AMA Plans to hold ten regional meetings within the next six weeks which include invitations to the presidents, presidents-elect, delegates, alternate delegates, and chief executive officers of state medical associations, to try to communicate with the grass roots physicians between regular sessions of the AMA House of Delegates. Your HMA plans to send representatives to our regional meeting in San Francisco.

AMA has announced that the Board of Trustees has selected Honolulu as the site for the 1979 Interim Meeting of the AMA House of Delegates. It will occur Dec. 7-10, 1979, at the Sheraton-Waikiki. For those members who have never attended a session of the AMA House of Delegates, the meetings are open and should be experienced by all physicians.

HMA and Hospital Association of Hawaii are now working in the formation of a joint committee to tackle the voluntary cost containment effort in hospital costs that were announced earlier by the American Hospital Association and the AMA. This committee will be involved in attempting to meet the mandate issued jointly by the AMA and the AHA to reduce the *increases* in hospital *expenditures* by 2% each year over the next two years. It is firmly believed that this goal is not an unrealistic one if every physician and hospital joined in this effort.

Frederick B. Glaser, M.D., well-known physician on drug abuse problems, has just completed a four-day evaluation of the Habilitat and its programs and will report his findings shortly.

Medical-Legal Interprofessional Code, updated and published in pamphlet form by a joint committee of the Hawaii Bar Association and the HMA, are still available from HMA. The January, 1978 *Hawaii Bar News* official publication reminded its members that this code exists to assist physicians and attorneys in their professional contacts. The Code covers such subjects as medical examinations, written medical reports, depositions, relationship of physician and the attorney prior to trial, physicians and the trial, compensation for medical reports, and deposition and court appearances. Copies available for the asking in HMA office.

Wanted Immediately! Hawaii licensed physician to work full-time in Ophthalmology Department of large medical group located in Honolulu—do general ophthalmology, with special training in vitreoretinal work. Interested physician call HMA office at 536-7702 for more information.

HMA Council Meets Friday, March 3, 1978, 6:00 p.m., at HMA office. If you have any issue to be placed before the Council, please let us know at the HMA office.

Announcing the 24th Annual Meeting of the Western Gerontological Society, April 9-12, 1978, Tucson, Arizona. To accommodate estimated 3,000 registrants with variety of interests, plan to hold 130, one and a half to three hour workshops on broad range of topics that affect lives of older citizens, ie, nutrition, drugs, employment, aging in rural communities, education, law and the elderly, legislative advocacy, minority concerns, death and dying, sexuality, and biological, psychological, and social aspects of aging. For further information, contact WGS, 785 Market St., Suite 1114, San Francisco, CA 94103.

Facts You Should Know about HAMPAC. HAMPAC is a voluntary non-profit unincorporated committee of individual physicians and

others. It is an independent and autonomous organization. HAMPAC has no branches or subsidiary committees. HAMPAC is not affiliated with any political party.

One of the purposes of HAMPAC is to improve government by encouraging and stimulating Hawaii's physicians and others to take a more active and effective part in legislative affairs.

Another purpose of HAMPAC is to encourage Hawaii physicians and others to know and understand the nature and actions of their government and the important political issues.

An additional purpose of HAMPAC is to assist Hawaii's physicians and others in organizing themselves for effective political action and in carrying out their civic responsibilities.

Membership in HAMPAC is available to any doctor of medicine, his spouse, members of his immediate family and others. There is no requirement that a HAMPAC member be a member of any other medical or political organization.

The HAMPAC Board of Directors consists of 27 members, 23 of whom are physicians who are members of HAMPAC and 4 who are members of the Hawaii Medical Association Auxiliary and are also members of HAMPAC.

Officers of HAMPAC include the Chairman, Doctor Leonard Howard, the Secretary-Treasurer Doctor A. Leslie Vasconcellos and the Assistant Secretary-Treasurer Elizabeth Bell. The Chairman and Secretary-Treasurer are elected by the Board of Directors from among the members of the Board at its Annual Meeting. No Chairman or Secretary-Treasurer may serve for more than two terms. The Assistant Secretary-Treasurer is appointed by the Board and serve at its pleasure.

All policy governing HAMPAC is determined by the HAMPAC Board of Directors.

If you have not already become a 1978 contributing member of HAMPAC and AMPAC you may do so now by sending your voluntary PERSONAL CHECK for $20 made out and addressed to HAMPAC at 320 Ward Avenue, Suite 200, Honolulu, Hawaii 96814. Contributions are not limited to the suggested amount. You may become a SUSTAINING MEMBER for 1978 through a voluntary contribution of $100. Neither the HMA nor AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of HAMPAC reports are filed with the Federal Election Commission.

1978 Workers Compensation

Fee Schedules

Now Available at HMA Office.



Editorials

The government *is* occasionally responsive.

If the reader is interested enough in health care planning, he may pull out from under the stack of accumulated but unread medical magazines, reports and papers on the doctor's cluttered desk at the office or at home—the HAWAII MEDICAL JOURNAL issue of December 1977—and read, or reread the editorial on page 394.

The editorial pointed out how a law—in this case PL93-641—can be perverted by bureaucrats. The perversion was a set of Federal Guidelines dated 23 September 1977 on how DHEW intended to implement "cost containment" by mandating a reduction in hospital beds, etc.

Now we have good news. On Friday, 20 January 1978, in the Federal Register Vol. 43, No. 14, DHEW issued the *revised* "National Guidelines for Health Planning."

So, what's "good" or remarkable about this? We'll explain.

Within the allotted 60 days from 23 September 77, plus 17 more days by extension, DHEW received 55,000 responses! 100 HSA's, 30 SHPDA's (these are both state health agencies), 50 hospital associations, 30 medical societies, 35 medical schools, 60 national associations and thousands of hospitals, practitioners and ordinary people poured in their comments. We did too.

Democracy at work? Indeed yes! Kudos to DHEW, if only for generating this type of response and grass-roots input.

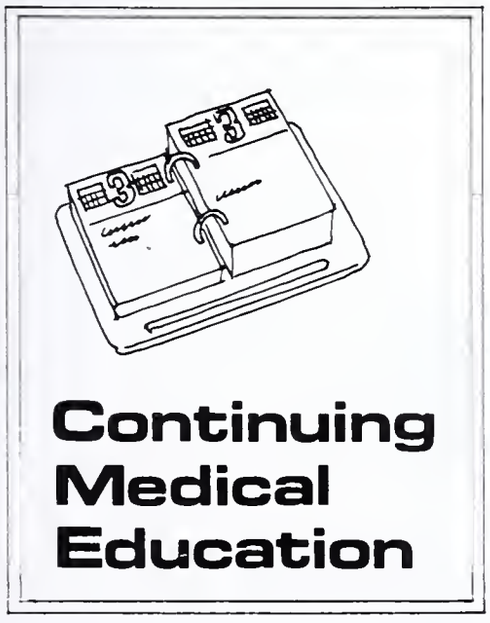
The subcommittees of Congress held hearings, as did the National Health Council on Planning and Development, and DHEW itself. Staid old DHEW admitted in the Federal Register: "The process of consultation, thus, has been extensive (*Ed:* We would prefer to describe it as an uproar of indignation, rather than a "consultation"!). At times the comments received have been spirited."

As a result, DHEW admits: "The Guidelines have been modified and improved on the basis of the comments received." And, they have. The interested reader is advised to scan them for himself. In brief, the new Guidelines do *not* contain the provision for mandatory conformance that is in the old statement. They now allow for a considerably greater local delineation, based on local circumstances. The Federal Guidelines—and they still exist—are to become "benchmarks." Health Systems Agencies are to be guided by these, as they develop their own guidelines, or to "be consistent with" those of the Feds.

Furthermore, it is gratifying to note in the Federal Register that the House of Representatives of the Congress passed a resolution on 6 Dec 77 to the effect that: "Guidelines should include sufficient flexibility to allow a HSA to recognize special characteristics in rural areas and, on the basis of these special characteristics, to establish a Health Systems Plan that varies from the National Guidelines, in order to provide health care services to rural residents." From responses received from Hawaii's two Representatives, Dan Akaka and Cec Heftel, in correspondence on the matter, they are both interested and were involved, and we thank them for that.

The government sometimes *does* listen to the people. But, it is the people—us—who must speak to our government!

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
3. U.H. Cardiology Grnd. Rnds., 1st Tues. 5:30 p.m. Rm. 506 Univ. Tower, Queen's.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

1. G.I. Conference, 3rd Tues., 8-9 a.m.
2. Medical Mortality & Morbidity, 4th Tues., 1:00-2:00 p.m.
3. Endocrine conf., 2nd Wed., 1:00-2:00 p.m.
4. Oncology Conf., Every Thurs., 7:30-8:30 a.m.
5. Surgical Mortality & Morbidity, 3rd Fri., 1:00-2:00 p.m.
6. Visiting Prof. Programs.
7. Ophthalmology Dept. Mtg. 1st Tues., 1:00-2:00 p.m.
8. Surgical Conf. 1st & 2nd Fri., 1:00-2:00 p.m.
9. Surgical Conf.—CPC, 5th Fri., 1:00-2:00 p.m.

(Contact: CME Dept.-Kuakini for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat): not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professors' Program.
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

St. Francis Hospital

1. Orthopedic Dept. Conf. 3rd Fri. ea. month. 7:30 a.m.-Med. Staff Board Rm.
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Prolessor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
7. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.
8. Dept. of Medicine Monthly Mtg., 2nd Tues. ea. mnth. 7:45 a.m. UH IV Classroom.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Prolessional Stall Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vinevard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu
Type: I, 1 hr/day, 1 day/mo from 12 mos
Fee: None Methods: AV, O, Pan
Dates: All yr, 12 hrs instruction

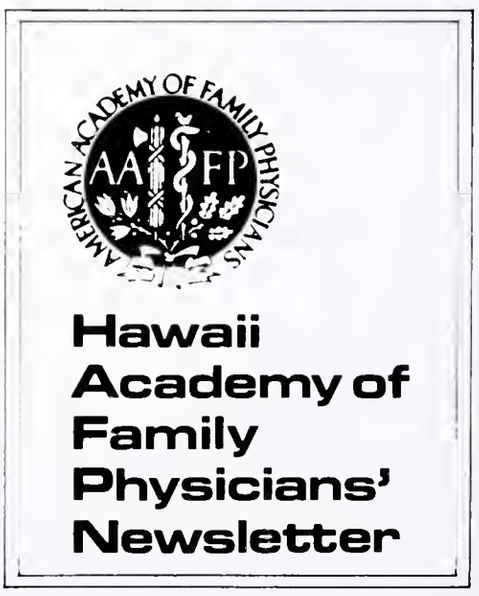
Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: I, 1 hr/day, 1 day/mo for 8 mos
Fee: None Methods: AV, Clin C, O, Pan, R
Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

Feb. 27, Mar. 2, 1978	Winter Trav. Med. Educ. Course at Royal Lahaina Htl., Maui, HI. 4 days-10 hrs. Fee $100. Kansas City SW Clin. Soc. 2220 Holmes St. K.C., MO 64108.
Feb. 27-Mar. 3, 1978	Clin. Mang. of Sexual Problems at Sheraton-Molokai Htl., Molokai, HI. 5 days-30 hrs. Fee $195. Med. Comm. & Serv. Assn. 315 Univ. Dist. Bldg. 1107 NE 45th St., Seattle, Wash. 98105.
Feb. 27-Mar. 3, 1978	Surg. Diagnosis & Therapy at Maui, HI. 5 days-20 hrs. Fee $300. Phil Thorek Post-Grad Courses, 850 W. Irving Park Rd., Chicago, IL 60613.
Mar. 7-8, 1978	Update on Tuberculosis; Ala Moana Htl. Honolulu. Co-Spon. Am. Lung Assoc. & Center for Disease Control, Atlanta, Ga. Contact: Rosemarie Respicio, (808) 537-5966 for further info. No fee.
Mar. 13, 14, 15, 1978	Child Neurology for the Practicing Pediatrician-update. Shriner's Hsp. Aud. Co-Spons: Dept. of Ped-John A. Burns Schl. of Med. & Kapiolani-Chldrn's Hsp. Contact: Wilma Schiner, Workshop Coord. 1319 Punahou St., Honolulu, HI 96826.
Mar. 14-18, 1978	Sports Med/Primary Phys. at Princess Kaiulani Htl., Waikiki, Hono., HI. 5 days-18 hrs. U. of HI Sch of Med. 1960 E West Rd., Hono 96822 & Amer Acad of Family Prac. Contact: Harold Brown, (808) 373-3745 or 373-3045.
Apr. 3, 7, 1978	14th Congress Pan-Pacific Surg. Assoc. Hilton Hi Village, Honolulu, HI., 7:30 a.m.-12:45 p.m.. For details write: Cesar B. de-Jesus, M.D., 236 Alex. Yng. Bldg. 1077 Bishop St., Honolulu, HI 96813. (808) 536-4911.
Apr. 16-22, 1978	Diving Medicine (General), Held at King Kamehameha Htl., Kailua-Kona, HI. 6 days-25 hrs. Cat. 1. U of HI Schl. of Med. 1960 East-West Rd. Honolulu, 96822. Contact: Dr. E. L. Beckman, Dept. of Physiology (808) 948-8652 or Harold Brown (808) 373-3745 or 3045.
Apr. 17-21, 1978	Emergency Med., 1978 at Royal Lahaina Htl., Maui, HI. 5 days-30 hrs. U of So Calif
Sept. 20-23, 1978	Genetics & the Pediatrician—What Every Ped. Should Know.—Held on Oahu & Maui. Contact: Wilma Schiner, Workshop Coord. Kapiolani-Chldrn's Hsp. 1319 Punahou St., Honolulu, HI 96826 for further info.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



J. I. Frederick Reppun, M.D.

New Members—Steven Azuma, UHSM '80; **Joan Junko Takeuchi Kawakami MD,** Practicing Affiliate is on Kauai with **Pat Cockett**—she was an anaesthesiologist and wants to become a Family Physician—she is married to retired Judge Norito

Kawakami; **David York Rogers,** Capt. MC is a Resident Affiliate at Tripler; **Alan T. Suyama,** UHSM '79; **James Shinobu Tsuji,** MD, is a new Active member; **Mark M. Yoshida,** UHSM '80 is the third new Student member. Welcome! We're growing!

News of Members—Garton Wall and **Howard Liljestrand** are life and inactive members respectively; **Gerald Yorioka** long gone to the Pacific Northwest, has finally formally transferred to the Washington AFP; **Pat Walsh** made news as the newly-elected President of the Honolulu County Medical Society—we're glad you're up there, Pat, and you're already making waves to revitalize ye ancient society! **William G. Podolsky,** Capt. USNR, was recently appointed Director of Clinical Services at the Pearl Harbor Branch Clinic; a year ago he was designated an Aviation Medical Officer by dint of completing a prescribed course of instruction—kudos, Bill! **Ben K. Azman** reads the HMJ—we know because he responded by saying he too attended the October 1977 Annual Scientific Session of the AAFP in Las Vegas; he also received his AAFP Fellowship degree in the convocation—congrats, Maui Ben!

Special Congratulations—to Betty Liljestrand—she will be receiving a Doctor of Laws honorary degree from Cornell University this May for the great work she has done with the local and national medical community.

We Lose—by resignation, Active member since 4/1967, **Takakazu Fukumura** because "I intend to concentrate my practice in the primary specialties of General Surgery and Gastroenterology as of 1 Jan 78." We hope our loss is Taka's gain.

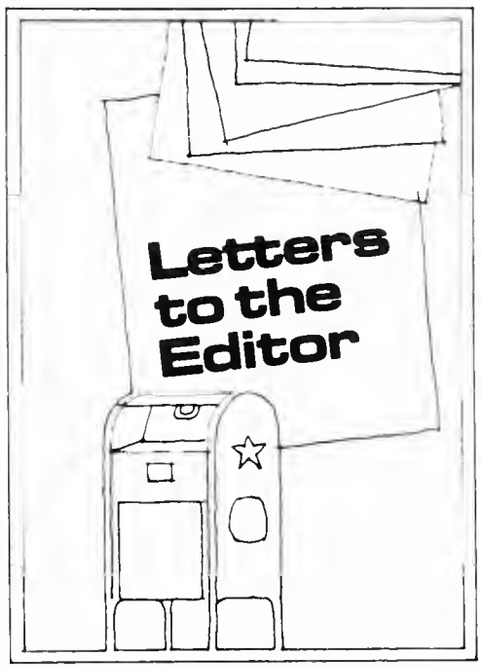
Dept of Regul Agencies—asked the Council to list the 10 most common procedures done by Family Physicians that might require Informed Consent signed statements. We listed: Suture of lacer., I & D, Excision of skin & Subq lesions & biopsy, L.P., aspir & inject of joints & tendons & fascia, endometrial biopsy, insertion of IUD, vasectomy, reduction & cast to simple, uncomplicated fractures, and obstetrical deliveries. Any others?

Annual Meeting & Election—was a success on 21 Jan 78 at the Hikai with AAFP Pres. **John Kelly** doing the honors. There were 75 present. *ELECTED* were: **Dave Swanson** pres-elect, **Pat Dietrich** sec'y, **Fred Reppun** treas.; Delegates **Felix Lafferty** & **Don Farrell;** Alt del **Fred Dodge** & **Fred Reppun;** for Councillor through 1980 **Doris Jasinski, Pat Walsh** & **Nathan Wong;** through 1979 to replace **Dave Swanson, Joe Fitzharris** and incumbents **Fred Dodge** & **Mike Hase;** through 1978 to replace **Ron Hattis** (resigned) **Mark Sowers** and incumbents **Fred Lam** & **Glenn Stahl. Tom Cahill** was installed as President, succeeding **Lincoln Luke.**

Membership—As of 31 Dec 77, we had 70 full-dues paying members, 6 Practicing-Affiliates, 4 Resident Affiliates, 38 Student members, 12 Life, 6 Inactive for a total of 136, which ranks us 44th out of 57 states and others.

CME—The Family Practice Residency Program at Tripler holds weekly Wednesday Conferences that are hour-for-hour category "P;" call **Dave Swanson** or Jean Reppun for details re, topics and times. The Australians are coming! 7 to 13 April at the Hyatt Regency Hotel, the GPSA (General Practitioners Society of Australia), which might be comparable to the USA's AAPS, are conducting conferences on medico-socioeconomic subjects and have invited Hawaii's physicians to attend. **Tom Cahill** and **Fred Reppun** have accepted invitations to be on their panel Sunday morning 9 April. Doctors of Hawaii are invited to that particular "Joint Meeting." Remember the Pan-Pacific Surgical from 1 to 7 April. AAFP is co-sponsoring with the American College of Cardiology "Contemporary Management of Acute Myocardial Infarction by the Family Physician" 30 March through 1 April in Sarasota, Florida for $175 registration fee.

Next Dinner Meeting—HAFP holds its next dinner meeting at the **Jasinski** home in Manoa on 1 April 78, a Saturday; the guest speaker on socio-economic aspects of medicine will be Phil Jones MD of the Straub Clinic on "Patient-Doctor Relationship;" the medical topic speaker will be **Dr. Hsia,** a geneticist at Children's Hospital.



To the Editor:

What must happen to physicians to awaken them to the fact that socialized medicine is here? National Health Insurance? When that time comes, it will be the mere finishing touch on a system that has been socialized for years. To me, socialism is excessive government intervention and regulation, and if anybody doubts that we have that now, he's wearing blinders. It has been a gradual, almost imperceptible change for most physicians, but as someone coming recently upon the scene of private practice, things like SHPDA, Act 219 (mandatory liability insurance), hospital cost control legislation, the inflexible, expensive, and often ridiculous regulations imposed by numerous agencies such as OSHA, the sloth-paced bureaucracy of the FDA, government meddling in the professional philosophy on advertising, and the self-righteous interference in our prescribing policies (ie, package inserts),—these things mean that we cannot practice our profession or plan our future without a politician's approval.

Who should know best about medical planning? We should! And because we've refused to become involved and speak with a unifying voice, we have people like Edward Kennedy and Joseph Califano telling us what we can do.

I cannot believe that our politicians have apparently totally ignored Britain's ignominious medical and economic situation and are heading us in the same direc-

tion. At the core lies the politicians' philosophy: They must help us, because we and our patients cannot make intelligent decisions ourselves.

The ultimate answer is simple, but will involve a major sacrifice for all of us, at least initially: We must refuse to accept government payment of any kind, for any service that we do as part of our profession. It has become sadly axiomatic that the strings attached to government funds gradually form a noose for those who accept them.

Gerald A. Hiatt, M.D.
Kailua

Join the club, Dr. Hiatt! Bully for you! We could not agree with you more! Every doctor who reads a package insert and refrains from using a drug for a non-FDA-approved purpose is contributing in a small way to the enslavement of our profession. "Rage, rage against the dying of the light!"–Ed.



Friday, January 6, 1978, 5:30 p.m.
320 Ward Avenue

PRESENT

Drs. Marion Hanlon, George Goto, Calvin Sia, Douglas Bell, William Hindle, Herbert Chinn, Patrick Walsh, Russell Stodd, James Williams, Thatcher Magoun, Calvin Kam, John Edwards, Leonard Howard, Alexander Roth, Felix Lafferty, Neal Winn, Denis Fu, and Arch Wigle. Also present were Dr. Roy Kuboyama, Mrs. Dorothy Sheperd, Dr. William Dang, Mr. V. Thomas Rice.

EXCUSED

Drs. George Mills, Rowlin Lichter, Arnold Siemsen.

ABSENT

Dr. Peter Kim

CALL TO ORDER

The Meeting was called to order at 5:30 p.m. by President Marion Hanlon.

MINUTES

The minutes of the meeting of September 21, 1977 were approved as circulated.

REPORT OF THE TREASURER

The House of Delegates mandated that all expenses for 1978 be approved by the HMA Council. The Executive Committee recommends to the Council that specific items be processed automatically as follows:

Salaries, Auto Expenses, Computer Reports, Council Expenses, Insurance and Bond, Lease Rent for Office Equipment, Meeting Expenses, Postage, President's Assistant, President's Contingency Fund, Retirement Contribution, Stationery/Printing/Supplies, Taxes, Travel (for AMA meetings or official business to Neighbor Islands), Auxiliary, Hawaii Medical Journal, Roster, Depreciation, Interest/Special Equipment Loan, and Repairs (small amounts).

It was also recommended that the item for Special Authorized Expenses/HTR be permitted with approval of the Executive Director or President.

ACTION:

It was moved, seconded, and passed that those items listed above be processed for payment on an automatic basis.

November 1977 Financial Statement: It was recommended that the monthly financial statement be submitted to the Treasurer for his review and that he report any items of significance to the Council rather than reviewing the report in full detail at each Council meeting.

ACTION:

It was moved, seconded, and passed that the monthly financial statements be circulated to the Council for their perusal and that the Treasurer comment at each meeting on any significant items rather than reviewing the report in full detail at each meeting.

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Dear Doctor:

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S. Cabacugon, M.D.
Medical Division

1441 Kapiolani Blvd./Suite 1203, Honolulu, Hawaii 96814/Phone 955-6686

ACTION:

It was moved, seconded, and voted to approve the November 1977 financial statement subject to audit.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. Legislative Committee: Dr. Howard reported that the HMA Auxiliary has been meeting with legislators to receive comments regarding health concerns and that the committee spent their first meeting reviewing HMA position papers from previous years. He recommended that the Council approve the retention of Attorney Kazuhisa Abe as HMA legislative counsel for the 1978 Hawaii State Legislature.

ACTION:

It was moved, seconded, and approved to retain Attorney Kazuhisa Abe as 1978 legislative counsel.

Dr. Kuboyama discussed the Medicaid and School Health Programs under consideration by the Legislature. He will follow these areas in the coming months. Dr. Hanlon announced that he has asked the Health Manpower Committee, chaired by Dr. Claude Caver, to look into the area of cost containment.

HAMPAC: According to HAMPAC Bylaws, the HAMPAC Board of Directors is appointed annually by the President of the HMA with the approval of the Council. The following were approved by the Council:

Leonard Howard, Chairman; A. L. Vasconcellos, Secretary-Treasurer; Elisabeth Bell, Assistant Secretary-Treasurer; Bernard W. D. Fong, Vice Chairman; Roy Kuboyama, Richard Ando, Raymond deHay, Rodman Miller, William Moore, Timothy Wee, Thomas Whelan, Calvin Sia, James Matayoshi, Pete Okumoto, Mark Sowers, Sakae Uehara, Patrick Aiu, Katok Chuang, Peter Kim, Yonemichi Miyashiro, Bobby Mills, Alice Tucker, Naomi Yamashiro, Albert Chun-Hoon, and George Goto, P. H. Liljestrand, L. Q. Pang.

Dr. Howard reported that HAMPAC plans a workshop for January 14 in cooperation with AMPAC. He urged all Council members to attend.

B. Building Committee: The Building Committee met preceding the Council meeting and recommends that the minimum lease rent base be set at 95¢ per square foot. The committee also agreed to continue the contract with the present management company. The 1978 Building Fund budget was reviewed and it is recommended that Council approve the budget.

ACTION:

It was moved, seconded, and passed that the building committee report and budget be passed as outlined.

C. Ad Hoc Committee on Self Insurance: At the last Council meeting, approval was given to consult with an actuary regarding the self-insurance proposal presented by Paul Brown and Company. The actuarial report has been received and has been referred to the Self-Insurance Committee. A meeting with Argonaut Insurance Company was also held and it appears that the amendments to the law setting up the conciliation panels and so forth have had a positive effect. It was recommended that the HMA apply for a decrease in professional liability insurance premiums for the coming year.

ACTION:

It was moved, seconded, and passed that the HMA apply for a 20% decrease in malpractice insurance premiums because of the statistics that are now available.

D. TV Radio Committee: The Committee has submitted a budget to the House of Delegates requesting funds for the purchase of video tapes as well as production costs. The present producer has found it necessary to charge for production costs and the committee has explored alternatives to keep a medical program on cable television and requests permission to utilize all of their 1978 budget for production costs.

ACTION:

It was agreed that the TV Radio Committee be permitted to utilize their budget for production costs.

E. Public Relations Committee: A copy of a proposed publicity code was circulated to the Council. Inasmuch as the committee chairman was not present, it was recommended that he be invited to meet with the HMA Executive Committee to review the reasons for the proposed changes in the code and to report back to the Council at a future meeting.

F. Emergency Medical Services: Dr. Dang reported that bills are being prepared for introduction into the State Legislature to continue the EMS training program and to allow ambulances to charge fees-for-service.

G. Act 219 Committee: The Act 219 Committee chairman recommended that HMA subscribe to a weekly periodical on liability news.

ACTION:

It was moved, seconded, and passed that HMA

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UNFINISHED BUSINESS

A. Cancer Center/Cancer Control Council: A copy of Dr. Hanlon's December 29 letter to Dr. Matsuda was circulated and referred to statements that had been made at recent meetings of the Cancer Control Council. Dr. Hanlon reported that he met with Chancellor Douglas Yamamura who asked that HMA postpone any decision regarding the relationship of the HMA to the University of Hawaii and the Cancer Center of Hawaii for six to eight weeks. He also reported that the CCH CORE Grant would be resubmitted to NCI on February 1.

ACTION:

It was moved, seconded, and passed that action be deferred until the next Council meeting.

A letter was reviewed regarding the current value estimate of a physician's time as a volunteer to the Community Cancer Program.

ACTION:

Inasmuch as it has been the position of the HMA that each physician base his fees according to whatever is usual and customary, it was recommended that HMA reaffirm its stand for this principle without naming a specific figure.

NEW BUSINESS

A. Peer Review: HMA was requested to participate with the Attorney General's office in reviewing the medical practices of certain physicians. HMA was asked to form a panel or a committee of medical experts in the various medical disciplines to work with members of the University of Hawaii Medical School.

ACTION:

It was recommended that Attorney V. Thomas Rice talk further with the Attorney General on this matter.

B. Foto Medic: The HMA was asked to evaluate an emergency I.D. packet to be distributed by Foto Medic, Inc. It was noted that HMA had previously gone on record as being opposed to endorsement of any commercial ventures and that the policy be continued.

ELECTIONS

At the first Council meeting of the year, it is the custom to elect members to those committees elected by the Council. The following were elected or appointed by the Council:

Bureau of Research and Planning: Drs. William Dang, Richard Omura, William Iaconetti, and Rex Couch (3-year terms)

Cancer Commission: Grover Batten (3-year term) and Chairman of the Commission. One representative of the UH Medical School will be appointed at a later time.

Mabel Smyth Board: Dr. Elmer Johnson; Alternate Dr. Walter W. Y. Chang

Finance Committee: Grover Batten, Elmer Johnson, Marcelino Avecilla, William Dang, and Richard Omura (one-year term) plus the county medical society treasurers; HMA Treasurer William Hindle, Chairman.

EMS Board: Dr. Livingston M. F. Wong

REPORT OF THE AMA DELEGATE

Dr. Chinn reported on the AMA meeting noting that a full report of the National Commission on Medical Care Costs will soon be circulated to all medical societies. He noted that the delegates voted to allow each hospital to determine its own criteria for accepting podiatrists on the staff, reiterated the rights of medical staff members to serve on hospital executive boards, believe that brain death should be determined by the individual physician, and referred a request for payment of medical services to victims of Hiroshima to the Board of Trustees (700 persons—200 in Hawaii).

REPORT OF THE COUNTY MEDICAL SOCIETIES

Dr. Stodd reported that Maui County will meet with Dr. Rex Kenyon from AMPAC at their next meeting. He noted also that there is strong support to remove Maui Hospital from the Act 97 Hospital System and he hopes HMA will support Maui County Medical Society in this position.

ADJOURNMENT

The meeting adjourned at 9:30 p.m.

MEETING OF THE HAWAII TUMOR REGISTRY, INC.

The Council elects the 9 Board of Trustees to the Hawaii Tumor Registry. Elected were: Drs. Calvin Sia,

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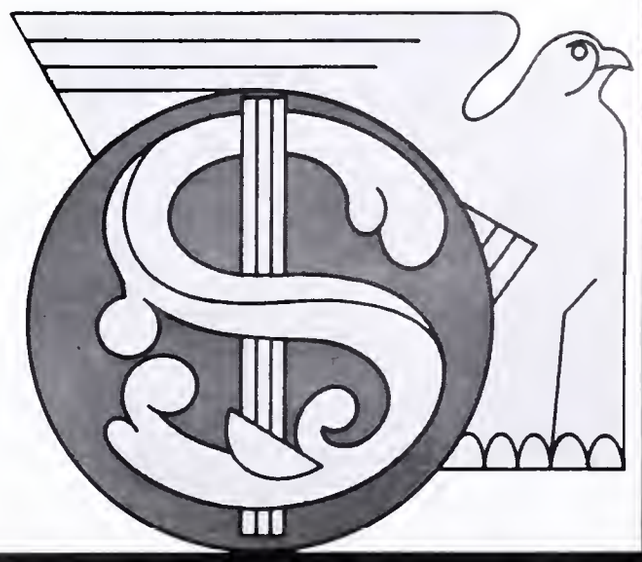
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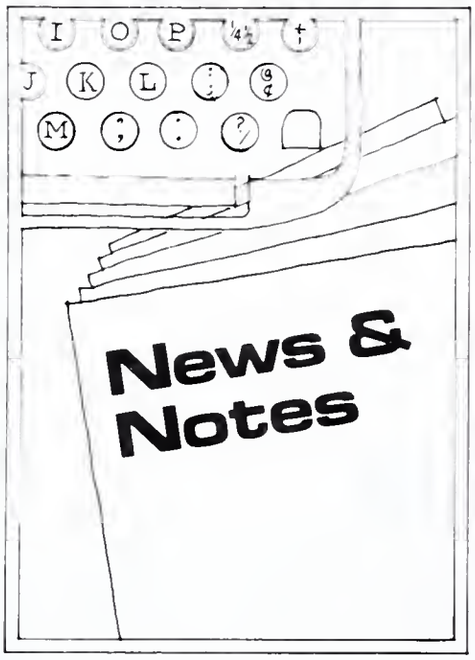
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Marion Hanlon, Douglas Bell II, William Hindle, George Goto, Herbert Y. H. Chinn, Grover Batten, William W. L. Dang, and Paul T. Condit. Dr. Reginald Ho was elected as alternate.



HENRY N. YOKOYAMA, M.D.

Life In These Parts

George Daacon, our favorite *Advertiser* columnist has this to say about our column: "Closet pornography afficionados say the smuttiest material in town can be found in the back pages of the otherwise serious HAWAII MEDICAL JOURNAL."

Maui scuba diver **Kenneth Strong** announced that the "hyperbaric unit" at Maui Memorial was finally operational. Kenneth estimates that the unit will be used in diving related cases 4 to 10 times a year and in non-diving related cases once or twice a day . . . His advice for a patient suspected of bends is to lie with feet slightly elevated and body turned slightly on his left side (in case of embolism) and to breathe pure oxygen . . .

Al-Anon which has been in Kauai since Spring 1977 is a fellowship separate from Alcoholics Anonymous which was created to meet the needs of families of alcoholics. Al-Anon is established in 70 countries with 13,000 groups and 2,000 Alateen groups (for teenagers).

Air Medic, a 5-year old firm operating out of California transports the ill and injured. It arranges transportation of stretcher cases and the like on any carrier and if necessary, can set up a whole mobile intensive care unit on board a plane.

Bertram Weeks, drive chairman for Ka Lima O Maui (Maui Rehabilitation Center) announced that the drive netted the goal of $25,000 in contributions . . . Another Maui fund drive for $5,000 has reached the $3,500 mark. The fund is to cover the first year of liability insurance for "Run For Your Life" program for cardiac patients. President Michael Savona plans to start the program by January . . .

Patients in Leeward Oahu were confused as they approached the entrance of former Leeward Hospital only recently renamed Pearlridge Hospital. Another new sign read "Kinkaid Ranch Hospital." "My God, they've changed the name again!" Fortunately Kinkaid Ranch Hospital lasted one day during a filming sequence of Hawaii Five-O . . . (Submitted by **D. R. Canete,** medical director)

The State Attorney General's office is requesting $36,000 from the legislature to match $324,000 in federal monies. The fund will set up a special 11-member unit to investigate and prosecute the supposed abuse and fraud in Hawaii's $70 million medicaid payments. Former deputy city prosecutor Rich Eichar has already been hired to head the unit. Rich says that "probably up to 90% of improperly claimed funds results from negligence and unfamiliarity with the rules . . . Criminal fraud, which will be difficult to prove, will be the exception rather than the rule." *(Ed: Such a waste of taxpayer money . . . The funds could be better used in patient care instead of investigating non-existent fraud . . .)*

A U of H School of Public Health task force headed by Russell Hicks, assistant professor of medicine, has recommended that the legislature allow the use of marijuana by glaucoma patients not responding to conventional medication. It also recommends investigative research in the use of marijuana as an antinausea drug for cancer patients on chemotherapy . . .

The Hawaii Right to Life, Inc including physicians **Patrick Stern** and **David Hannan** has filed a Circuit Court lawsuit challenging state welfare payments for elective abortions . . .

Kona's **"Pedro" Chisato Hayashi,** who semi-retired recently at age 75 was honored by hundreds of friends and former patients. Pedro recalled his horse and buggy house call days in poverty stricken Kona when he was paid with coffee, chickens and all kinds of things to show appreciation . . .

A $455,000 out of court settlement was reached in a 3rd Circuit Court case involving a 1973 auto accident and alleged medical negligence. Thomas and Daisy Thomas of Hilo were seeking $2.3 million in damages from Katheryn Hanes, a minor, her parents, Wilmot Boone, Kona Hospital, Straub Clinic, Hawaii County and State Dept. of Transportation . . .

An ambulance fee bill was reintroduced. The bill is critical since the City expects to lose federal funds for training emergency personnel . . . The HMA which has run the EMS training program is recommending $50 per ride to make up for the anticipated loss of federal funds. An estimated 24,000 patients are carried annually by the city's ambulance service . . .

Greenwood's Laws . . .

Skinner's Constant (Flanagan's Finagling Factor): "That quantity which when multiplied by, divided by, added to or subtracted from the answer you get, gives the answer you should have got."

Horner's Five-thumb postulate: "Experience varies directly with the equipment lost or ruined."

Gumperson's Law: "The probability of a given event occurring is universally proportional to its desirability."

Chisholm's Law of Interaction: "Anytime things appear to be going better, you have overlooked something."

Soo's Law: "A slice of bread and butter when dropped will always land on the buttered side, except when dropped for the express purpose of proving the law."

Asshole Variable: "When everything is planned down to the last paper clip and you can't lose and then some asshole screws it all up."

(Sent in by **Fred Greenwood,** our favorite humorist and UH Med School endocrinologist)

Professional Moves

The galloping horse has overtaken the slinking serpent and we are now in the Year of the Horse (Ma Nien . . . The lunar year of 4676) . . . The Horse symbolizes strength, speed, and endurance and is a propitious year for the youthful, spirited and fit. The zodiac claims that those born in the Equine Years (ie, 1894, 1906, 1918, 1930, 1942, 1954 or 1966) are quick witted, industrious, and have a good business sense. But they are also stubborn, impatient, headstrong to the point of shunning sound advice and are emotionally intense and often plunge into love's brambles . . . *(Ed: Sounds like some people we all know).*

Anyway, the avalanche of last year seems to have subsided. Into the Queen's Physicians Office Bldg. relocated OB Gyn men **John Ohtani** and **James Wong** (Suite 404); internist-cardiologist **Stewart Matsumoto** (Suite 509); surgeon **Pill Whoon Hong** (Suite 804) and the Hawaii Anesthesia Group, Inc. of **Kenneth Chinn, John Pearson, Harriet Pien, Eugene N. Wong, Francis Lim** (Suite 709).

Eye man and TV moderator **John Corboy** relocated his Wahiawa office to 302 California Ave. while his Waikiki office

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remained unchanged at 305 Royal Hawaiian Ave; skin man **Philip Hellreich** of Kailua Dermatology Associates, Ltd. opened a Kaneohe Branch Office at 45-461 Pua Inia St. On Kauai, family practitioner **Ronald Burkhart** joined the Kauai Medical Group, Inc. in Kapaa.

We missed a few announcements from the Year of the Serpent including eye man **William John Holmes** who relocated to Alexander Young Bld (Suite 352), infectious disease man **Richard Frankel** who moved into Suite 912, Queen's Physicians Office Bld; GP **Hilarion Dayoan** who opened at the Waipahu Professional Center; internist **Nicanor Joaquin** who moved into Suite 217, 1869 No King St.; and cardiologist-tennis player **Jef Sol** who moved into Suite 610, 1441 Kapiolani Blvd . . .

Conference Humor

During a UH Grand Rounds discussion on patient compliance, **Max Botticelli** told the story of his patient on antihypertensive medication who even saw a urologist for his impotence. When Max explained that the impotence could be from the blood pressure medication, the patient teased, "Doc, the directional signal at the heliport must be your advertisement." For those of us who have never seen a directional signal, Max drew it thusly: [illegible] (Max swears the patient continued to take his medication, which shows good compliance) Max insists that clearly marked bottles with specific instructions are also a factor in compliance . . . "My wife mistook a diet pill one night for her birth control pill . . . She stayed up all night . . . Unfortunately, I couldn't . . . Promise, you'll never tell my wife . . ."

At the same conference, psychiatrist **John Streltzer** gave the following example of behavior modification in patient compliance . . . A mother went to see her physician because her two teenage sons were using foul language . . . The doctor instructed, "I want you to get M&M candy and reward them each time they speak without using a filty word and spank them with a big stick each time they use a filty word." Next morning, she asked her younger son, "What would you like for breakfast?" "Oh, Hell! Give me one of them goddam Cheerios." Whack! Then she turned to his brother and asked sweetly, "What will you have for breakfast?" "Damned if I know! But don't give me any of them sweet ass candies . . ."

Sportsmen

Alan Luning, our teller of 19th Hole jokes, made a historic hole-in-one on Thursday afternoon, Feb 9 at Mid Pac CC, on the 4th Hole with a No. 6 iron . . . As we recall, **Ed Emura, Ed Izawa** and **Richard Lam** also had their hole-in-one's on the 4th Hole . . . Ed Izawa won the Mid Pac Thursday Club's December trophy and Alan Luning tied with Ed Izawa for the January trophy . . .

"Pedro" Chisato Hayashi of Kona who retired at age 75 still makes housecalls and plays 4 holes of golf every afternoon. Chisato was an enthusiastic hunter and fisherman and an avid pilot. Pedro says begrudgingly, "As age creeps up, it's really hard to adjust," and is unhappy about curtailing his many activities . . .

"Queen's physician **Bill Lockwood** is no male chauvinist. He soloed twice last week—gliders and powered planes—and both of his instructors were females . . . The high flying doctor already has a seaplane license and a parachute rating . . ." (From Daacon's column)

Elected, Honored & Appointed

We must congratulate the newly elected officers and board members of the HCMS . . . **Pat Walsh** is the new president, **Walter Chang,** president-elect, **John Edwards,** secretary and **Andrew Morgan** treasurer. Board of Governors include **Edward Boone, Bernard Fong, Norman Goldstein, Thomas Lau, Neal Winn, Vincent Aoki, Allan Izumi, Gabriel Ma** and **John Morris** . . . Outgoing president **Ann Catts** did an outstanding job . . . Our thanks to her . . .

Hors de Combat

AMA president John Budd criticized President Carter's proposal to limit hospital price increases to a 9% ceiling as a "meat ax" approach unfair to both hospitals and consumers . . .

The MMH (Maui Memorial Hospital) controversy with the DOH rages on . . . The issue is a pediatric-psychiatric patient overlap on Medical 11 . . . **Donna McCleary,** MMH chief of pediatrics cited numerous examples of psychiatric patients attacking elderly patients in the ward, pulling IV feeding tubes out of the arms of sick children and tearing apart the nurse's station . . . Several speakers including **John Withers, William Kepler** and **Russell Stodd** have advocated removing the hospital from State jurisdiction and returning it to county control . . . An engineer of the State Department of Accounting and General Services surveyed the ward separation project, and estimated the cost to be $4,000, and promised immediate action. John Briley said, "This is terrific, but I don't see why it couldn't have been done 6-months or a year ago." Then along came objective thinker and philosopher **Sakae Uehara** who wrote the Maui News: "To pick on the Department of Health as the scapegoat is indeed evidence of unprofessional journalism . . . Instead of firing up the emotions of your readers over the symptoms of the disease, I suggest you do some professional digging to enlighten the public of the system which is the disease and the lack of money which is the deficiency leading to the disease . . ." Sakae then listed 5 pertinent questions the reporter should investigate before criticizing the DOH's George Yuen and Henry Thompson . . .

Miscellany

A new inmate at Oahu Prison was spending his first night . . . Someone yells, "356" Evervone laughs heartily . . . Someone else vells, "75" Again loud laughter . . . The inmate was curious and asked his cellmate, "What goes?" The cellmate explained, "We're telling jokes . . . We know the jokes cold so we just call them out by joke number . . ." The new inmate tries his hand, and yells, "205" Nary a laugh or giggle . . . "How come?" he asks his cellmate . . . "Well, some guys can tell a joke right and some can't . . ." (From **Walter Loo's** repertoire . . .)

A golfer arrives at the country clubhouse with his pet gorilla and pays the pro for two green fees. "You mean your gorilla plays golf too?" the pro asks incredulously . . . "May I play with you . . ." "Sure, you're welcome." As they arrive at the first hole tee, the pro says, "How about a lil' bet with your gorilla like $100 a hole?" The friendly golfer says, "Well, if you insist . . . I'll just tag along as caddy." The gorilla gets up to the tee and whoosh! He drives 400 yards onto the green and 6 feet from the pin . . . The pro stammers, "Errr . . . I just remembered I have to be giving a golf lesson in a few minutes . . . Here's a $100 and we'll call it fair and square." As he starts to walk away, the pro asks, "Incidentally, how's his putting?" The golfer replies, "Just like his drives . . . whoosh! (As told by **Jim Mertz** at a KCH noon conference . . .)

Our "Angels"

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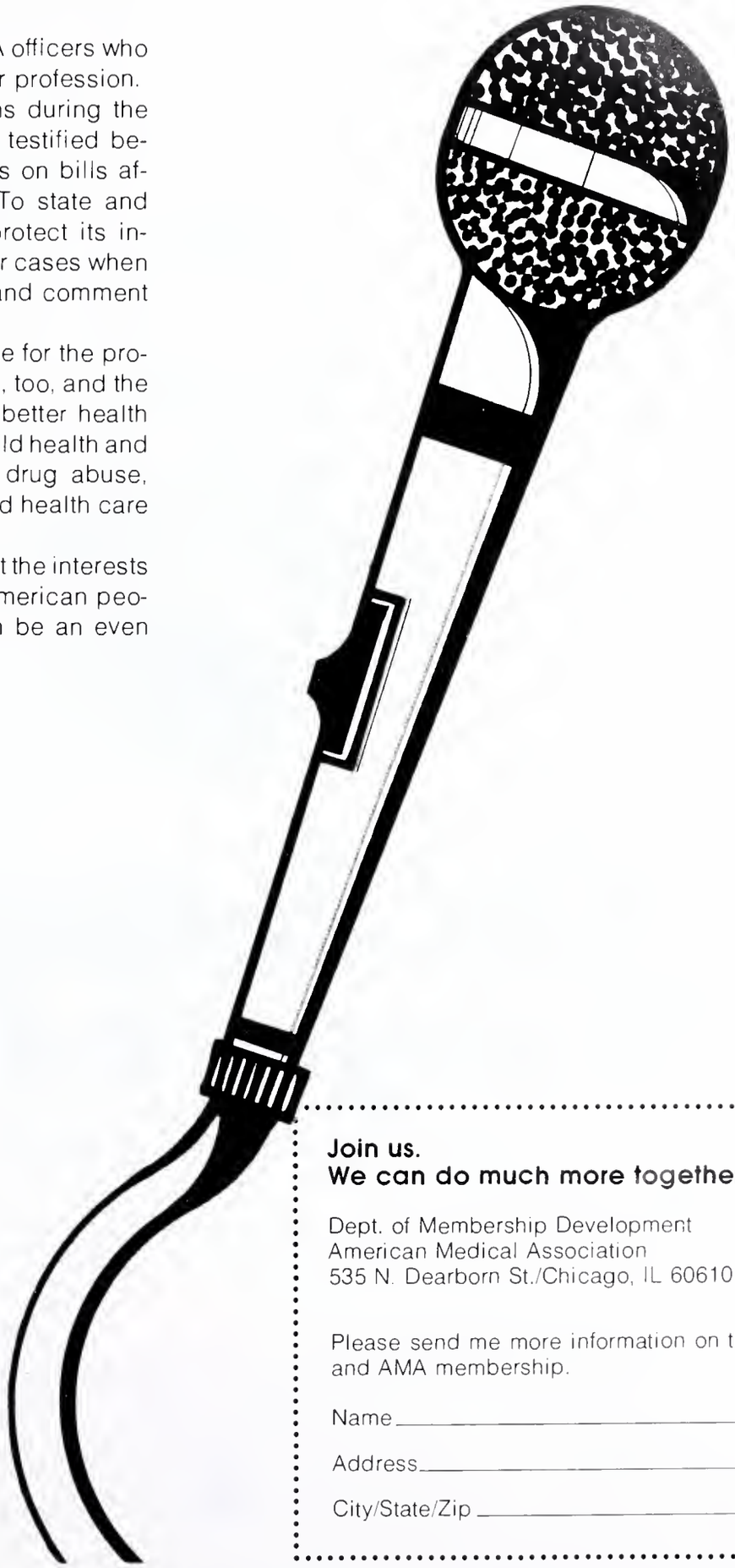
"Mr. Chairman, Members of the Committee, I am Dr. Holden ... Dr. Palmer ... Dr. Beddingfield ... Dr...."

These were but a few of the many AMA officers who have gone to the Hill to represent our profession.

On more than two dozen occasions during the 94th Congress, AMA representatives testified before Congressional health committees on bills affecting the delivery of health care. To state and explain our profession's views. To protect its interests. In addition, there were 72 other cases when the AMA submitted written analysis and comment on legislation.

But the AMA isn't solely an advocate for the profession. It's an advocate for the public, too, and the passage of legislation for more and better health care. Legislation such as maternal, child health and crippled children services. Alcohol, drug abuse, and mental health programs. Improved health care for American Indians.

The AMA goes to the Hill to represent the interests of the American physician and the American people. With your support, the AMA can be an even more effective spokesman.



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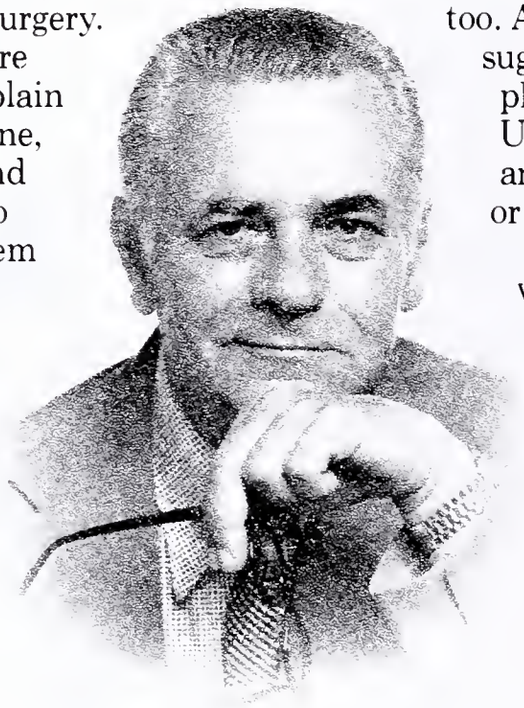
From what our HMSA members tell us, more doctors seem to be perfecting that old fashioned 'bedside manner.'

To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk about these important matters.

We think these are both healthy signs. We can all do our part to promote this kind of helpful dialogue.

We'd like to hear from you, too. Anytime you have a suggestion or question, please let us know. Usually we can have an answer for you in a minute or two.

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Old Fashioned Dialogue is Back.

HMSA Utilization Review Department
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MARCH, 1978
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Hawaii Medical Journal

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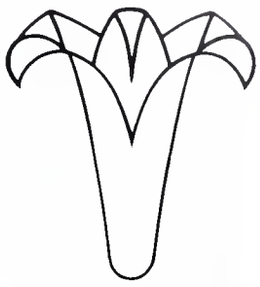
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In Memoriam



Norman R. Sloan, M.D.

1902-1977

Dr. Norman R. Sloan was born in Philadelphia, Pennsylvania on June 15, 1902, and died in Honolulu, July 25, 1977. He received his medical degree from the University of Pennsylvania and a Master of Public Health degree from Harvard School of Public Health. He also studied at the London School of Tropical Medicine and Hygiene. Very early in life he decided to become a medical missionary for the Lutheran Church, having been influenced by the minister of St. Mark's Temple Lutheran Church in Clifton Heights, Pennsylvania, which he attended as a boy with his family. The minister of the church, Dr. August Pohlman, was a medical doctor as well.

Norman went to the Lutheran Hospital in Monrovia, Liberia, in 1928, and stayed until 1934. He described the hospital as a number of mud and thatch buildings with a galvanized iron shack for surgery. He visited the hospital about five years before his death and said he found it quite modern then.

Very soon after his work in Liberia was terminated because the government authorities would not let him return (he never was told why) following a voluntary furlough away, Norman received an offer to go to the Virgin Islands and work in a leprosy hospital. He spent several months at the Carville, Louisiana Leprosarium before starting his work in Christiansted, Virgin Islands, at a hospital containing about 100 leprosy patients. This was the beginning of his long career as a leprologist. While on this assignment, he met and married his wife, Catherine, who was to predecease him by over 10 years.

There he also met Dr. L. Clagett Beck, who was instrumental in getting him to Hawaii in 1940 to become Medical Director of Kalaupapa Settlement, where he remained for ten years. There were about 400 patients at Kalaupapa when Norman went there.

Norman left Kalaupapa in 1950 because of what he described as a "political hassle," and went to New York, where he took a short appointment in a Veterans Administration hospital. In 1951, he took a job with the South Pacific Commission, which called for him to inspect leprosy facilities. He travelled widely, stopping for visits in New Guinea, Truk, Ponape, Tinian, and

continued page 94

COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,0 Persons When States Adopt Cooperating Laws–He (the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14 The Social Security Bill, pr a broad program of unempl insurance and old age p and counted upon to bene 20,000,000 persons, became day when it was signed by dent Roosevelt in the pres those chiefly responsible f ting it through Co s.

Mr. Roosevelt cal "the cor erstone which is being me s comple ri to

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen

TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

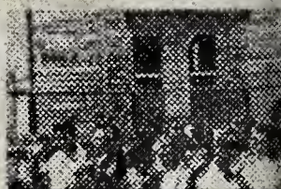
The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

JOL SIGNI the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

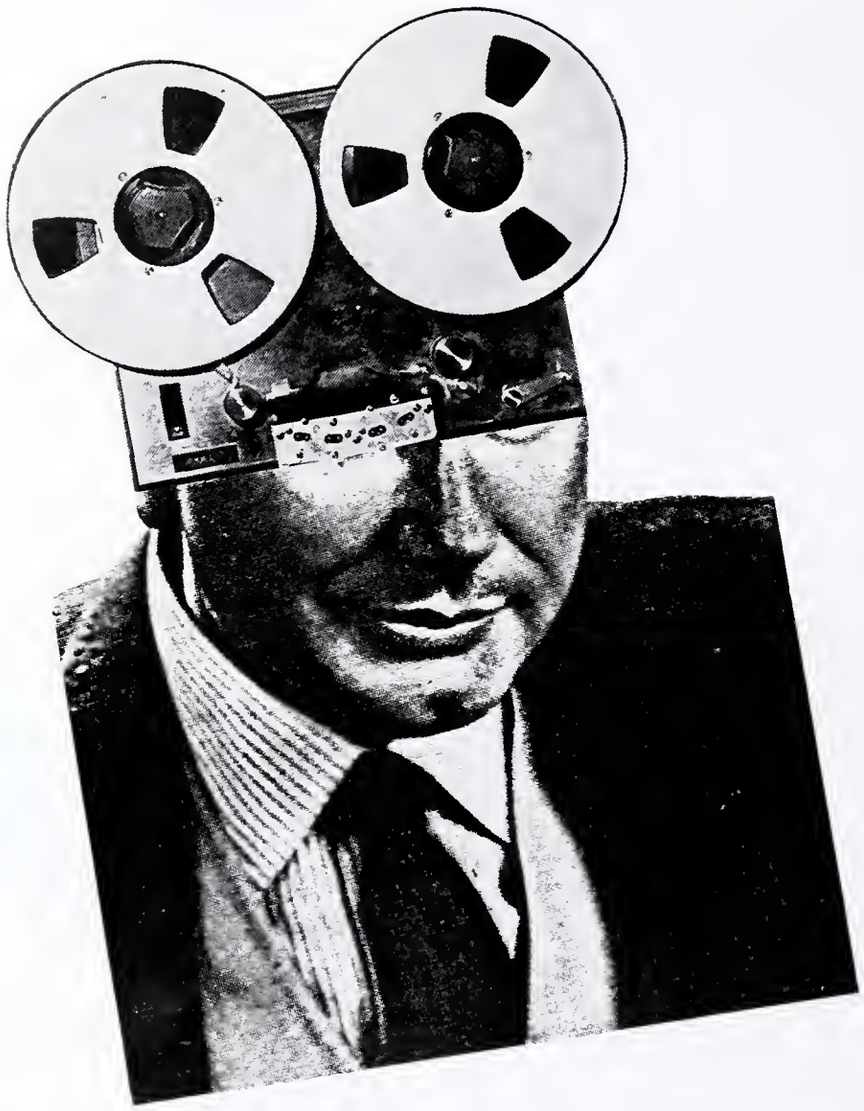
These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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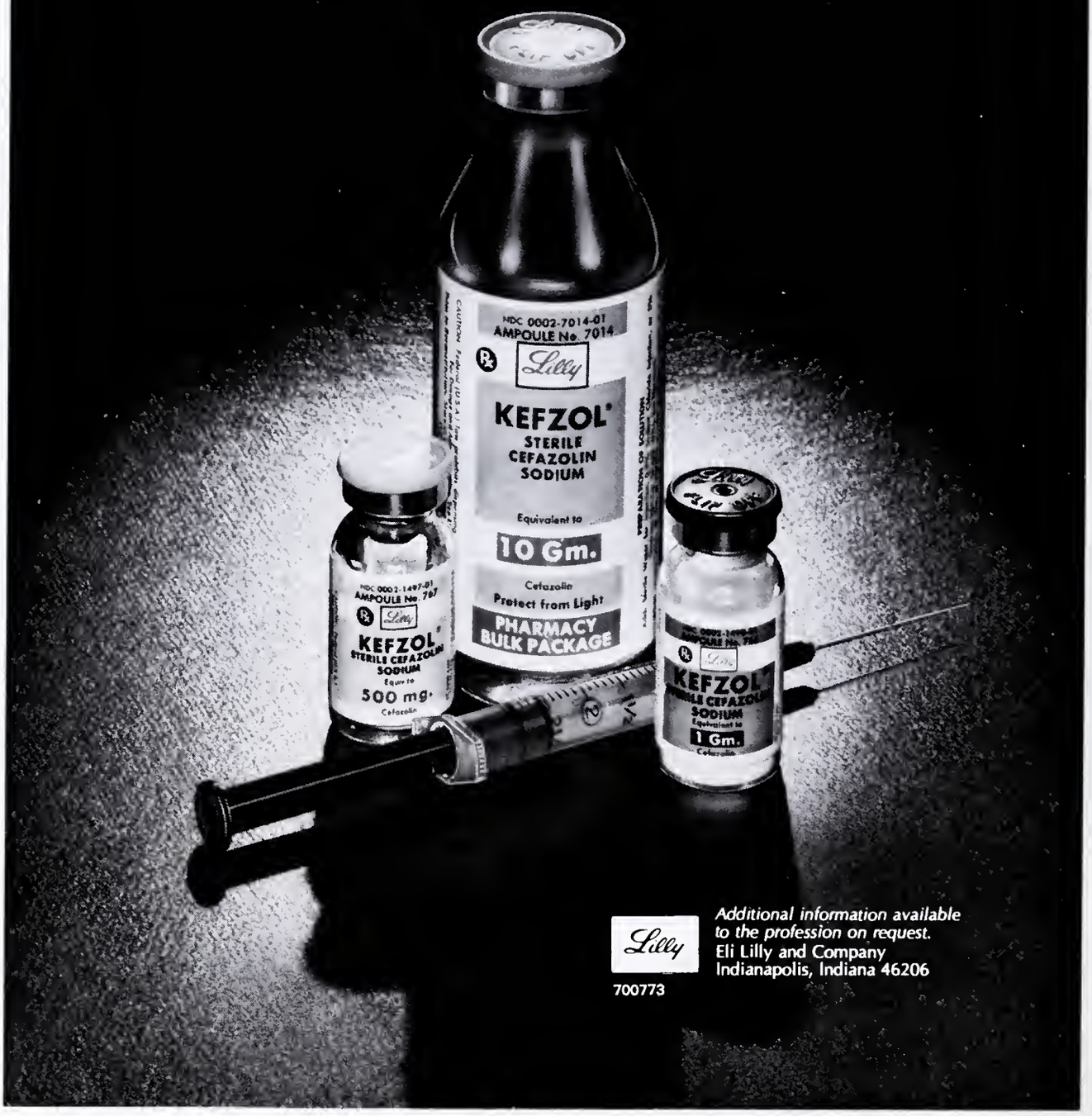
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Adverse Reactions: Most frequent: lightheadedness, dizziness, sedation, nausea and vomiting; more prominent in ambulatory than nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Others: euphoria, dysphoria, constipation and pruritus.
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Study of the Knowledge, Attitude and Practice Among Teenagers in Hawaii Related to Reproduction, Family Planning and Sexuality

SUSAN HANCOCK,* *and* GLORIA KAW,* *Honolulu*

• *This study was concerned with the knowledge, attitude and practice of teenagers in Hawaii regarding reproduction, family planning and sexuality. The study was conducted by Hawaii Planned Parenthood (HPP) for the purpose of exploring the extent and source of the family planning and human sexuality education Hawaii's students are receiving, and to determine the need for expanded education. In addition, the attitude and actual practice of teens was examined in relation to sexual activity and the use of contraception. An attempt was also made to measure the accuracy of the knowledge our sample group had regarding reproduction, venereal disease, and contraception.*

Data Collection

A questionnaire was distributed on the islands of Oahu, Kauai, Maui and Hawaii in various intermediate and high schools and to several community youth groups. Students were administered the questionnaire by either an HPP staff member or by a teacher or group leader who had reviewed the questionnaire with HPP staff. The questionnaire was discussed with the students prior to their completing it. Any confusion regarding the wording of certain questions or the intent of the study was thus cleared up. Students were given the option to decline to answer any question, but were encouraged to complete as much of the questionnaire as possible.

A total of 1600 questionnaires were collected. Excluding the respondents who were 18 years old or over, the final total number for the study was 1586.

The questionnaire was designed by the HPP Education Committee and responses were collected from January 1975 to June 1976.

The Sample Population

Data was processed for a sample group ranging between 13-17 years in age, the majority (94%) being 15, 16, or 17 years old. Females made up 58%, 42% were males.

The ethnic composition of the study group is similar to that of the general population of Hawaii (excluding military). Hawaiians and part-Hawaiians are slightly under represented in the sample group. Filipinos, Chinese and Koreans were slightly over represented.

The neighbor islands are somewhat over represented, based on the total population size of those islands. This is particularly true of Kauai. For the purpose of comparison, some tables show statistics for the neighbor islands separately from those of Oahu, a significantly more urbanized island.

Not all schools chose to participate in the survey and therefore the cooperation of individual teachers and youth group leaders was solicited to assist in the recruiting of a sample population.

Discussion and Summary of Major Findings

Concerning reproductive and sex education, the majority of the sample group responded that they had received some sex education in school. For Oahu youngsters, school was the primary source of their sex education. Neighbor island teenagers depended more heavily on their friends as a primary source for sex education. Only 11% of the total group named their family as that resource from which they had acquired most of their education regarding sex.

The quality, thoroughness, and even availability of the Family Life/Sex Education curriculum in Hawaii's schools varies widely from school to school. Much is dependent upon the priority teachers, administrators and parents place on

*Health Education, Hawaii Planned Parenthood, Inc.
Accepted for publication August, 1977.

Fig. 1.—Question: *Where have you received most of your information on sex?*

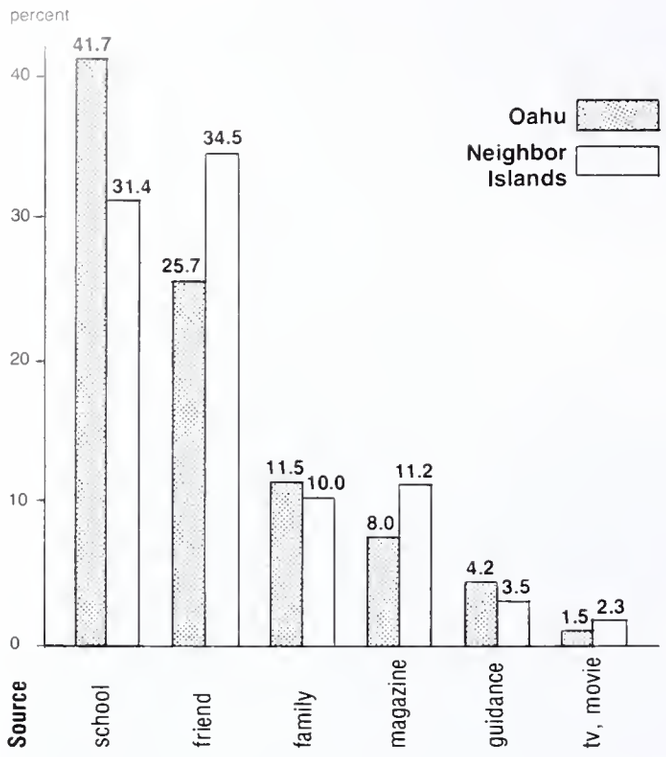


Fig. 2.—Question: *When was birth control information given to you in school?*

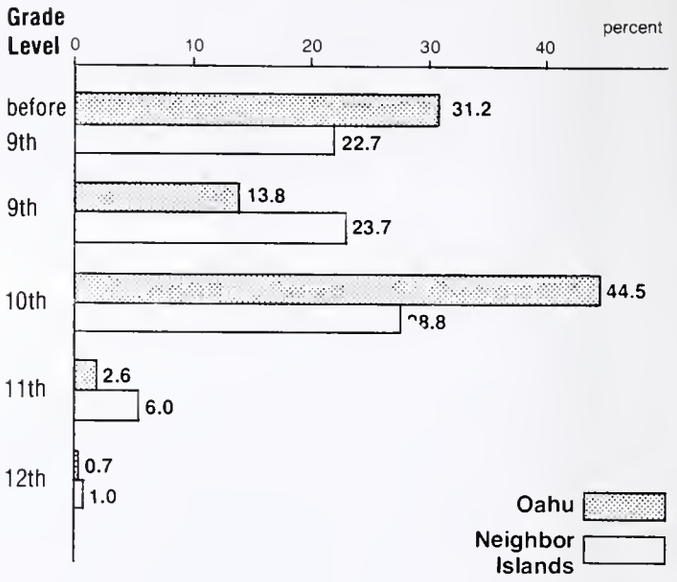
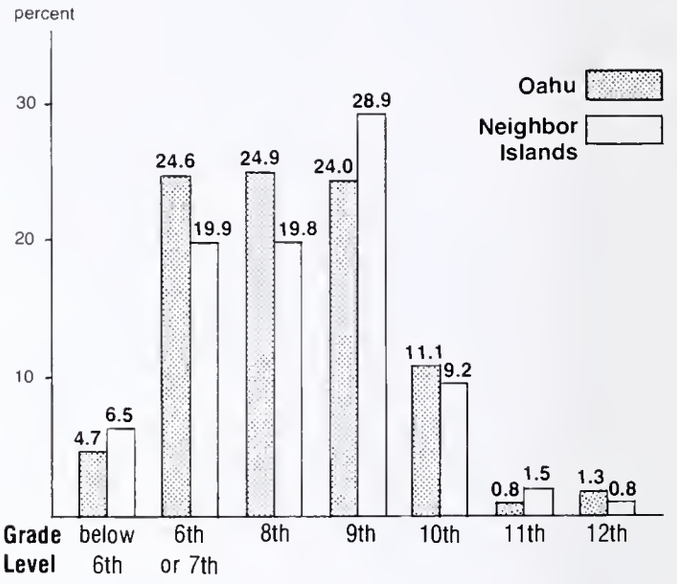


Fig. 3.—Question: *At what grade level do you think birth control information should be given?*



such curriculum in education, a teacher's comfort and skill levels in presenting the curriculum and on a student's class scheduling.

The data indicate that few parents take the responsibility of providing their children with knowledge about human sexual development and guidance concerning the expression of their sexuality.

Most of the teens questioned stated that they knew about reproductive anatomy, contraception, venereal disease and how far one can go sexually before risking pregnancy. However, several "knowledge testing" questions indicated that many did not have accurate information. For example, when asked, "At what time of the month is a girl most likely to get pregnant if she has intercourse," only 36.5% answered correctly. There was also misinformation regarding prevention of venereal disease. Of the teenagers responding to the questionnaire, 28% believed that spermicidal foam would prevent V.D., while an equal number said that they would use birth control pills or withdrawal to prevent V.D.

The knowledge gap between what young people actually know, and what they believe they know, may be one reason for many of the unwanted pregnancies among teenagers.

More than 75% of the respondents in this study felt that birth control information should be given at the 9th or lower grade level. Approximately 45% of the respondents had received such information at the 9th or lower grade level.

A public opinion survey of 1033 adults in Hawaii, conducted by Hawaii Planned Parenthood in 1974, showed that 75% of the persons questioned felt that birth control information should be made available in public schools. In addition, the largest number favored providing this information at the 7th grade level. Responses from this survey do not substantiate the concern expressed by some school administrators that the community will object to birth control education being in the curriculum.

The public opinion survey and this present study indicate that both adults and adolescents recognize the need of young people to have birth control information included in the curriculum at an earlier age than it is usually given. The need for early and comprehensive sex education is further indicated in the study data, by the responses to the question, "At what age did you first have sex?" Of those respondents who had had sexual intercourse, 19.8% on Oahu and 16.3% on the neighbor islands, had done so prior to the age of 14.

TABLE 1.—*Oahu teenagers response to Question: At what age did you first have sex?*

AGE	TOTAL = 307
6-10	6.5
11	1.9
12	4.6
13	6.8
14	20.5
15	24.8
16	18.9
17	4.9
Did not specify age	11.1

TABLE 2.—*Neighbor Island teenagers response to Question: At what age did you first have sex?*

AGE	TOTAL = 196
6-10	1.5
11	1.0
12	6.1
13	7.7
14	20.0
15	32.6
16	25.0
17	6.1

TABLE 3.—*Sexual activity of minors questioned*

TOTAL	OAHU (974)	NEIGHBOR ISLAND (612)
Never have had sex	62.3	56.6
Have had sex	31.5	32.0
No Answer	6.2	11.4

Tables 1 and 2 indicate that most of the teenagers in our sample group who had had sexual intercourse had first done so at age 15. The reader should keep in mind that this study deals with minors (those under the age of 18) and that the majority of sexually active teenagers probably do not experience sexual intercourse until the age of 18 or 19.

Most of the respondents in the study group stated that they would seek a pregnancy test if they thought they or their partner might be pregnant. However, less than half of respondents stated that they would seek a pregnancy test if their parents were to be notified if the test were positive. That most of the teenagers we questioned stated that they would not seek a pregnancy test if their parents would be notified may indicate a need to change Hawaii's current law which requires physicians to notify parents of a minor with a positive test. In relation to this response, 34% answered "They would wait until 2 or more periods had been missed before seeking a test for themselves or their partner." This response may also reflect hesitancy on the part of minors to seek pregnancy testing for fear of parental notification. Early pregnancy detection is particularly important in the case of teenage women. Whether choosing to terminate her pregnancy or to carry her pregnancy to term, the pregnant teenager needs special care. Statistics on abortion in Hawaii indicate that among those abortion patients having their abortions at the twelfth week of gestation or later, women 17 years old and younger comprised the largest group.[1] One cause for late abortions among the teen population may be that they are seeking confirmation of pregnancy later, due to fear of parental notification of test results. In addition, if the fear of seeking service is lifted, minors with negative pregnancy tests can be started on a contraceptive plan and the very serious problem of an ill-timed teenage pregnancy may be prevented.

In the case of pregnancy, this group of teenagers most often answered that they would choose "not to marry," as opposed to marriage, and to "have the baby and keep it," rather than choosing abortion or releasing the child for adoption. These responses are in keeping with what seems to be a national trend away from "obligatory marriage" due to a pregnancy and a tendency for single parents to keep their infants. The teenage parent usually has special needs and requires special attention. Social service agencies and educational institutions will find a need to alter or expand services to meet the needs of this growing group of adolescent parents and their children.

Emphasis, however, should be on prevention of teenage pregnancy via education and the availability of contraceptive services for minors. Education must address not only biological facts relating to reproduction and the mechanics of contracepting, but also clarification of values and decision making related to sexual activity. Young people are called upon to make decisions regarding many aspects of their lives and the sexual aspect is no exception.

Teenagers today receive conflicting messages regarding how they should behave sexually. Parents, peers, advertising, TV-movie industry and religion may each present a different position; then decision making regarding sexual expression becomes confusing and frightening. Parents and educators can be of great assistance to young people by involving them in discussions concerning choices, feelings and responsibility in relationships and the expression of their sexuality. They can support teenagers by reassuring them that they do have a choice and that their beliefs are valid and important.

References

1. "Factors Assoc. with Length of Gestation At Time of Abortion: A Study of Legal Abortions in Hawaii" Cobb, et.al.

Transvenous Pacemaker Placement In a Community Hospital

A Ten-Year Experience

J. JUDSON McNAMARA, M.D., VICKY GRANT, R.N. *and* STELLA MATSUDA, *Honolulu*

• *A review of 242 patients who underwent transvenous endocardial pacemaker from 1966 to 1975 was conducted.*

The data indicated a high incidence of electrode withdrawal (15%) and an unusually high incidence of skin erosion over electrode or pacemaker sites. The latter appears to be due to a high incidence in the present series of small statured, thin Oriental patients with minimal subcutaneous fat and little consequent protection against pressure necrosis.

Followup was very poor during the first 2 years of placement, with only 28% documented patient contact between one and 24 months post implantation.

The overall results, however, indicate that the pacemakers were placed with 0.4% mortality and 57% and 35% 5-year and 10-year survival, respectively.

These excellent long-term results, in spite of several areas of deficiency in the present series, confirm the unequaled superiority of the transvenous endocardial route for cardiac pacing.

Recent development of easily applied myocardial electrodes has renewed interest in limited thoracotomy for placement of permanently implanted cardiac pacemakers. The advantages of the myocardial electrode include superior electrical and physiological pacing characteristics as well as avoidance of a variety of complications of the transvenous route. The tradeoff is an increased morbidity and mortality from the extra-pleural pericardiotomy and general anesthesia.[1]

A wide variation is reported in the frequency of various complications of the transvenous unit. We reviewed our series over a 10-year period to discover what specific complications we had encountered with any significant frequency, in an effort to see what impact a shift to the more frequent use of direct myocardial electrodes might have on our results. The data indicate an incidence of most complications consistent with that in most reported series. Two important characteristics of the series, however, include a 28% lack of followup between one month and 24 months after implantation and exceptionally high incidence of pacemaker erosion.

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Methods

In general, the technique for pacemaker placement has been consistent with that previously reported.[2-6] Wide variations have occurred over the years, however, in the use of 1. a specific venous route (external jugular versus internal jugular versus cephalic), 2. prophylactic antibiotics, 3. drainage of the pacemaker pocket, and 4. unipolar versus bipolar pacing modes. All patients had pacemakers placed under fluoroscopy in x-ray with meticulous skin cleansing and aseptic technique.

Patient Material

A total of 242 patients underwent placement of a permanent transvenous endocardial pacemaker from 1966 to 1975. There were 160 men and 82 women. Mean age for the entire group was 66.6 years.

Indications for pacemaker placement generally fell into two broad categories: any patient with a documented episode of complete heart block regardless of clinical status and patients with significant atrial arrhythmias and unexplained vertigo or syncope. A more detailed breakdown of the reasons for pacemaker placement is seen in Table 1.

The pacing mode and types of electrodes are shown in Table 2. Demand units are used almost

TABLE 1.—*Reason for Replacement*

Heart Block - 3°	136
Sick Sinus	69
Tachyarrhythmias	20
Postop	5
Congenital	3
Other	9

TABLE 2.—*Unit Information*

Pacing Mode	
Synchronous (demand)	77%
Asynchronous	23%
Electrode Configuration	
Unipolar	24%
Bipolar	76%

exclusively at the present time. Of all units implanted, 71% were made by Medtronic. The remainder were divided among units made by CPI, General Electric, Cordis and Vitatron.

Results

Electrode malfunction occurred in 36 instances (15%) with the initial implantation, including electrode fracture (11), electrode withdrawal (19), ventricular perforation (5) or exit block (6). Four other instances of electrode withdrawal were encountered during battery replacement.

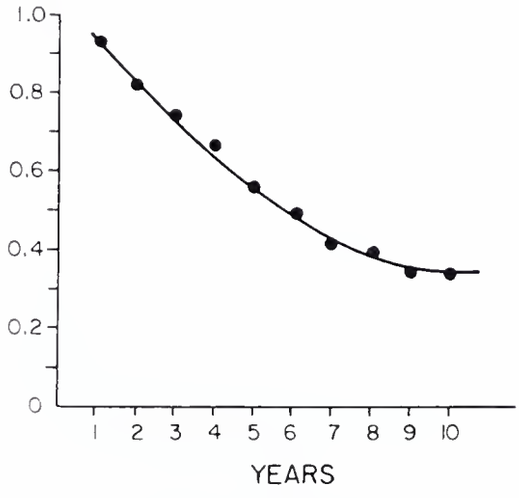
Skin erosion occurred in 49 patients, 11 in the electrode site and 38 over the pulse generator. Six instances of infection in the pulse generator pocket included 3 later episodes (1-2 months) that may have been associated with incipient erosion as it is occasionally difficult to tell which came first.

TABLE 3.—*Complications*

Electrode failure (36 primary)	40
Skin erosion	49
Electrode 11	
Battery 38	
Infection (3 early, 3 late)	6
Cardiac arrest	8
Battery change	215

Eight documented episodes of cardiac arrest occurred as a consequence of electrode failure or battery malfunction, the latter usually occurring in patients with inadequate followup. Among patients in this series, 28% had no documented evidence of a pacemaker check between one and 24 months following implantation. Followup, however, improved dramatically beyond 24 months.

FIG. 1.—*Cumulative Probability of Survival*



Observed survival rates for all patients show a 57% 5-year survival and a 35% 10-year survival (Fig. 1). Only one patient died in the immediate post-insertion period. A post-mortem was not obtained, but cardiac tamponade was considered the most likely possibility. Ten late deaths occurred in situations in which the pacemaker may have contributed to their demise, although it was not primarily responsible. This includes two patients with sepsis, one with electrode erosion and the remainder with other complications including electrode withdrawal or cardiac arrest. (Table 4)

TABLE 4.—*Causes of Death*

Pacemaker related	10
Other illness	64
Surgical implantation	(1)

Discussion

The present study confirms the relative ease and safety of the transvenous approach for cardiac pacing. Our reported long-term survival compares favorably at 1, 5 and 10 years with a number of other studies.[7-10]

The procedure of insertion itself was followed by only one death (0.4% mortality), a low mortality in a group of elderly patients with a variety of other disease processes.

Electrode malfunction remains a problem, although fracture has virtually been eliminated as a cause of electrode failure. Electrode withdrawal occurred with greater frequency (23 of 40 electrode failures, 19 of 36 occurring acutely or 8%) than in other series.[11] The decreasing use of the unipolar electrode may improve this result as

over half of the electrode withdrawals occurred with a unipolar electrode which, in turn, comprised only 24% of the electrodes implanted.

A further factor in high incidence of electrode withdrawal may have been the short interval between placement of the temporary electrode and the permanent unit. A delay after placement of the temporary electrode, particularly in patients with a large heart, appears to have reduced ventricular failure, particularly the size of the R.V. cavity which appears to be an important factor in electrode withdrawal.

Late infections have probably been the result of pacemaker erosion rather than primary infections, but in these three instances it was impossible to tell which came first. The acute infection incidence of 1.2% is in line with that reported by others.[5,12,13]

The incidence of electrode or pulse generator erosion (20%) is far higher than that reported by others.[5,10,14] Surprisingly, the complication has been managed successfully in each instance. The reason for this high complication rate is, we believe, due to the high incidence of patients of Oriental extraction in our series. Migration of the pulse generator contributes to this problem as well. Many of these patients, particularly in the older generations, are very small, of short stature, slight build, very thin with minimal subcutaneous tissue. We believe that avoiding an electrode passing over the clavicle and use of smaller lithium power sources will reduce the problem of erosion substantially in this group of patients. Use of suture fixation of the pulse generator to the pre-pectoral fascia and subpectoralis muscle placement in selected cases may have also reduced this problem in recent implantations.

In general, this series compares favorably with groups reported from most other large centers. The major areas for improvement relate to inadequate followup between 6 weeks and 24 months, and an inordinately high incidence of electrode failure and skin erosion. One of the problems in a community hospital is that the work of a number of different physicians and surgeons are included in a series for study. This makes for some wide variations in techniques and expertise. In the present series, 8 different surgeons were responsible for one or more of the pacemaker implants. Currently, a centralized followup registry is being planned which should obviate followup problems. The impetus for this was provided by the erratic followup data reported herein. Furthermore, current standardization of procedures and methods may further minimize many of the observed complications with electrode failure and erosion.

In spite of a slightly increased incidence of minor complications, the present series emphasizes the safety and reliability of the transvenous approach. The only problems which might be obviated by direct myocardial electrodes relate to electrode malfunction, particularly with electrode withdrawal. However, the low acute mortality and the excellent long-term results suggest that direct myocardial electrodes cannot be implanted with as low risk, and should be reserved for selected patients where the transvenous route has failed or avoidance of risks of electrode withdrawal is particularly critical.

The study has then provided a useful mechanism for upgrading one aspect of pacemaker patient care in this community which may be helpful information for other institutions. It, furthermore, emphasizes the problem of skin erosion in very thin, elderly patients, and provides evidence of both the safety and efficacy of long-term pacing with permanent transvenous endocardial pacemakers.

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Review of Serum Digoxin Levels

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• *Ordering serum digoxin levels (dig levels) has become a commonplace practice for the clinician in both in-patient and out-patient settings. From a pharmacological point of view, this is feasible since serum levels are related to tissue levels following post-absorptive equilibration. From a clinical point of view this is often indicated for a number of reasons.*

Cardiac glycosides in general have a low therapeutic ratio; a very slim margin exists between therapeutic and toxic tissue levels. A prospective study on patients admitted to the Boston City Hospital demonstrated that between 7 and 23 percent of all hospitalized patients treated with cardiac glycosides experienced some degree of toxicity and that the mortality rate among toxic patients was more than twice that among nontoxic patients.[1] In another prospective study of patients treated with digoxin in 1970-1972 at Massachusetts General and Peter Bent Brigham Hospitals, Koch-Weser et al determined that the risk of digitoxicity was 2.12 times greater at the Brigham, where digoxin serum levels were not commonly performed.[2]

Dosing regimens are basically empirical. In the individual patient, it is difficult to predict a serum level from a given dose. This remains true despite the existence of elaborate computer programs and nomograms that integrate pharmacokinetic parameters to produce dosing regimens associated with low toxicity.[3,4] Peck and co-workers were unable to demonstrate any difference in serum level predictability between computerized dosage calculations and those arrived at by physician estimates.[5] This could have been because the methods used to date are largely based on assumptions that the volume of distribution (V_d) of digoxin is related only to lean body mass and that the half-life ($t_{1/2}$) and elimination rate constant of the drug are directly related to creatinine clearance.[3,4,6] A glance at data from the literature reveals that these assumptions are only approximate at best. V_d's have been found to be variable,[8,9] and the relationship of $t_{1/2}$ to creatinine clearance demonstrates similar variability.[4,10-12] Determinations of serum digoxin concentrations eliminate at least that part of individual variation in the dose-effect relationship that is due to differences among patients in absorption, distribution to inactive sites, biotransformation and excretion of the drug. Thus, the correlation between serum concentrations and clinical effectiveness of digoxin must be better than that between dose and effect. The clinician is better informed if he knows the concentration of a drug in his patient's body than when he knows only the dose prescribed.[2]

More specific clinical uses for dig levels are in patients with arrhythmias that might be due to digitalis toxicity, in patients with changing renal function, and in those with changing electrolyte or acid-base status. Also candidates are patients who are unable to provide an accurate drug history, those whose drug absorption is in question and patients who are not responding or are poor compliers.[7]

Therapeutic Ranges

When the dig level returns from the lab, it is expressed in nanograms per milliliter (ng/ml). A nanogram is 1×10^{-6} milligrams. Then, is the dig level within the therapeutic range? What is the therapeutic range and what are the reasons for the limits?

Usual therapeutic levels are in the range of 0.8-2.1 ng/ml, but it can vary from assay to assay. Each laboratory should determine or verify for itself the normal range of the assay it performs. Smith and co-workers found that 90% of patients with no evidence of toxic reactions to digitalis had serum dig levels of 2.0 ng/ml or less, while 87% of patients with arrhythmias had levels above 2.0 ng/ml. Overlapping serum levels between 1.6 and 3.0 ng/ml were seen in patients both with and without toxic reactions.[13,14]

The Assay

The assay in widespread clinical use now is the radioactive immunoassay (RIA) technique,

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which measures the amount of an antigenic substance (the drug, digoxin) by its ability to combine with an antibody which has high affinity and specificity for the antigen. There is a fixed amount of radioisotope-labeled digoxin (^{125}I) present, and the competition between this and the free digoxin from the patient's serum to form a complex with the antibody is the basis for the assay. The radioactivity present in the complex is then determined in a liquid-scintillation spectrometer or gamma counter. The amount of bound radioactivity found in the antibody complex will decrease with increasing amounts of free or unlabeled digoxin. The level of drug in the serum is then determined graphically from a calibration curve prepared from calibration standards.

Limitations and Interferences

Since each sample is calibrated against a standard curve and variability in the affinity and specificity of each antibody batch is a potential source of error, a standard curve must be run with each assay. It must be accurate.

Samples that contain radioactivity, eg. diagnostic tests in which gamma-emitting radioisotopes are used, will interfere with the assay.[15] Some kits have a Special Blank preparation method to correct for this.[16] There has also been some work done with homogeneous enzyme immunoassays for digoxin which would eliminate this as an interfering factor; however, the technique has not yet been accepted for widespread clinical use.[17,18]

In the past, there was suspicion that drugs with steroidal sructures, especially spironolactone and prednisone/prednisolone, would cross-react with the digoxin antibody to a significant degree. Zeegers and co-workers provided the most convincing evidence.[19] However, this is no longer an issue in the clinical setting. A more recent study, comparing I^{125}-labeled digoxin kits from 5 different manufacturers, concluded that spironolactone and prednisone do not cause clinically significant values for apparent digoxin, and that possible reasons for Zeeger's findings were that he probably used a Burrough-Wellcome tritiated (H^3) kit (not included in the study) and that two years had passed since his investigation, during which time significant changes may have been made in antibody specificity.[20]

Deslanoside and digitoxin, both possessing steroidal aglycone and carbohydrate moieties similar to digoxin, cross-react with the antibody 100% in the case of deslanoside.

Clinical Considerations

The ratio of serum to myocardial digoxin is relatively constant after post-absorptive equilibration (absorption and distribution), which generally takes 6-8 hours.[22] Therefore, blood drawn any earlier than 6 hours after the last dose shows more the absorption phenomenon than the relative amount in myocardial tissue and can vary within a wide range. Making it a rule of thumb to draw the blood at least 6 hours after the last dose will insure levels that realistically reflect the amount in tissue. Timing is important.

In the out-patient situation particularly, making interpretations on a serum level without knowing approximately how long since the last dose at the time the blood was drawn is risky. For example, if the patient had taken his last dose the day before and came in for his appointment before taking his daily dose, serum levels drawn then will reflect a "trough" level and will most likely be subtherapeutic, ie. below 0.8 ng/ml.

Whenever troubleshooting levels above or below the acceptable range, a check should always be made as to when the blood was drawn. Often, this is *the* influencing factor. On an in-patient basis, a hospital policy on dig levels could eliminate potential problems of this nature.

Earlier it was mentioned that digitoxin cross-reacts with the antibody for digoxin. The extent has been variously reported as around 3%.[16,23] In addition, digitoxin is partially metabolized to digoxin; therefore, a small amount of digoxin will be present to react with antibody whenever the serum contains digitoxin. This usually does not present a problem unless there is a question as to whether a patient is on one or the other, since a digoxin level will reflect the presence of a glycoside, but not necessarily rule out the presence of digitoxin. A simple solution of course, besides a careful drug history, is ordering two samples of serum—one for a digoxin level, the other for digitoxin. This could be especially important when a serum level is to be used as the basis for altering therapy or for ruling out digitalis toxicity.[24]

The question as to whether spironolactone and prednisone/prednisolone cross-react with the RIA is moot with the current kits now in use. The fact that a patient may be on digoxin and one of these drugs should in no way deter an order for a serum level if it is indicated.

In terms of applications, serum levels are helpful if below the designated therapeutic range in dose-response adjustments and if above, in signalling increased potential for or verifying suspected toxicity. If the reported level is within the therapeutic range, there is no assurance that the patient cannot manifest toxicity, thereby making it incumbent upon the physician to be constantly alert for the cardinal signs.

Summary

The optimum time to draw blood for dig levels is at least 6 hours after the last dose, ie. when serum and myocardial digoxin are in equilibrium. Deslanoside and digitoxin cross-react with the RIA antibody for digoxin, 100% and 3%

respectively. Gamma-emitting radioisotopes used in treatment or as diagnostic tools will interfere with the RIA.

With so many possible influencing factors, dig levels should be realistically perceived as only a guide and not a substitute for experience and proper clinical management of the patient. They are helpful in making decisions about patient therapy and together with clinical skills can be utilized to maximize therapeutic benefits and minimize the adverse effects associated with the use of digoxin.

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JON WON

Recreation Discounts for Physician again offered to HMA members, their families, and guests, by the Kahuku Sugar Mill for the "World of Sugar Tour" during 1978. Just present your County Medical Society membership card. The Mill, situated on Oahu's Northshore, opposite Kahuku Hospital, offers your entire family and visitor guests a multi-media excursion into the ways and means of sugar making. This one hour adventure makes old Kahuku town come alive as you become a mill worker for a day in the early 1900's. "World of Sugar" tour rates for HMA members, their families and guests are:

Adults (Reg. $3.50)	$2.50
Juniors, Age 13-17 (Reg. $3.50)	1.50
Kids, Age 7-12 (Reg. $2.00)	1.00
Kids 6 and under	Free

The tour and show is conducted daily from 10:15 a.m. to 4:30 p.m. beginning every 30 minutes. A recent addition to the Sugar Mill complex is the Cane Train Restaurant, featuring distinctive dining facilities and menu choices for individuals as well as private parties of up to 250 people. Remember: Mom's free on Mother's Day and Dad's Should Know about HAMPAC and the HMA policies . . . The Hawaii Medical Political Action Committee, formerly known as the Hawaii Physician League for Good Government, was reorganized as HAMPAC in 1963 as an independent and separate political committee of physicians and others. Since 1963, HMA has funded HAMPAC's *educational* activities.

Members of the HAMPAC Board of Directors are appointed by the HMA President and confirmed by the HMA Council for terms of one year. No member may serve on the Board more than ten years.

Members of the HAMPAC Board neither individually nor collectively report to or are directed by the HMA Council or President. HAMPAC operates separately and independently from the HMA and all other associations. The Chairman of the HAMPAC Board is invited by the HMA President to address the HMA House of Delegates at HMA's Annual Meeting each year.

The most important connection between the HMA and HAMPAC is the fact that the leadership of the HMA strongly endorses the concept of physician involvement in the political process. HAMPAC is a vehicle to encourage physicians and their families to be increasingly active in the political process. HAMPAC feels that the physicians and their families in state representative and senatorial districts can be good judges of candidates. HAMPAC makes contributions to candidates, contributions which back the voluntary efforts of physicians and their families. HAMPAC assists and encourages all types of groups and individuals to form political action committees or to become otherwise involved in the electoral process. HAMPAC considers this missionary work in the public interest and has counselled all types of groups, regardless of philosophy or the candidates they might support.

Cost Containment is the byword for both individual and institutional providers of health care during the next two years. Hospitals and physicians alike have been asked to embark in an ongoing voluntary cost containment program that will limit 1978 and 1979 medical and hospital cost *increases* to 2% less than the year preceding. If hospitals and physicians working together cannot meet these goals, then big brother HEW will take over and re-institute price controls. The voluntary cost containment program, sponsored by the AMA, the American Hospital Association, and the Federation of Hospitals, gives physicians new opportunity for leadership.

"A Symposium on the Geriatric Patient" will be held on Sunday, April 9, 1978, at the Ilikai Hotel. There is no fee for this meeting but advance registration is required. This symposium starts at 8:30 a.m. and includes luncheon and a poolside cocktail reception in the afternoon. Speakers for the program will be Dr. Edward Stainbrook and Dr. James Henry from the USC School of Medicine, and Dr. Ruth Weg from the USC Ethel Percy Andrus Gerontology Center. Programs and pre-registration forms have been mailed to all HMA members. The symposium is jointly sponsored by the HMA, the HNA and the Hawaii Pharmaceutical Association, and is being put on with the generous cooperation of Lederle Laboratories.

The AMA has Sent Ms. Barbara Chapman, Associate Director, AMA Division of Public Relations, in response to HMA's request for advice

and consultation on an approach to public relations for the HMA and the HCMS. Ms. Chapman has spent four days in Hawaii meeting with various news media people and others in attempting to determine the viewpoints of such people regarding physicians as well as the HMA and the HCMS. Her report to the Executive Committees and PR Committees of the HMA and HCMS has provided a great deal of valuable information and insight to the HMA and HCMS, and results of this consultation will be forthcoming shortly.

Put Your Best Foot Forward Hawaii! Walk! March of Dimes Superwalk, Saturday, April 15th. Starts 6 a.m., McCoy Pavilion, Ala Moana Park. All ages welcome. Sponsored by the Hawaii Hotel Association. Registration, pledges, information, call 536-1045.

Medical Office for Lease, Beretania Medical-Dental Plaza, 848 South Beretania St. Seven exam rooms, two consult rooms, 1626 sq. ft. Contact Drs. Robert Clingan or Allan Izumi at 521-6741.

President-Elect George Goto, AMA Delegate Dr. Herbert Chinn, and Executive Director Jon Won attended one of six meetings held by the AMA for medical society leadership in an attempt to increase communication between the AMA and member physicians. The meeting included discussions of cost containment, membership legislative developments, and the JCAH. The Voluntary Cost Containment program sponsored by AMA, AHA, and FAH was described by AMA Board Chairman Dr. Robert Hunter in which he warned of problems implicit in the proposed federal hospital revenue ceilings. Mandatory ceilings would make it easier for inefficient hospitals to comply than for efficient institutions. President-elect Dr. Tom Nesbitt briefed the leaders on the AMA-sponsored National Commission on the Cost of Medical Care, noting that it gives the profession "new opportunity for leadership—new credentials for the public debate about costs." Other discussion leaders at this San Francisco meeting were House Speaker William Y. Rial, M.D., Trustees Joseph F. Boyle, M.D. and George H. Mills, M.D., and John Affelt, M.D., President of JCAH. The states described their progress in implementing the voluntary cost containment programs. Many states reported that they were conducting successful membership recruitment programs.

HMA/HCMS Office currently receiving between 20 and 25 inquiries each month from physicians on the mainland or who are in the islands on vacation regarding practice opportunities in Hawaii. While the snow and cold weather during winter prompts many of these inquiries, they do come into the office year round. While some people feel that the State already has an adequate physician population, if any physicians or clinics do have need for more physicians, please contact the HMA/HCMS office—we have many names in almost every specialty. We can give you names and addresses, but in no way recommend any of these as we have not checked them out.



The family that has a family doctor, sticks together.

It is a cause for serious concern, to learn by word of mouth, or by reading the newspapers, of the violence that seems to be ever more prevalent in our schools—mainly in the public schools.

There may be many reasons why this apparent epidemic. Not the least of these is the "break-up" of the family.

Those of us who look after the health of small children and who treat their ailments must surely agree that it is possible for the physician to sense whether both parents are working outside of the home, or not. The youngster who, typically, is rudely awakened before dawn, fed a breakfast in the face of the child's non-hunger, and is then bundled up for a long ride in a car in stop-'n-go traffic amidst noxious fumes, and is finally deposited at a baby-sitter's to face the daily trauma of a separation from both parents at one time, shows the effects of this in a doctor's office: He is fearful, insecure, demanding, clinging and uncooperative in most instances.

In such instances, the physician often finds the parent(s) ignorant of the child's daily habits of eating, playing and elimination; the doctor wishes it was the baby-sitter bringing in the child, as one who could be relied on to provide meaningful answers to the queries about the child's symptoms and behaviour. The fact that the baby-sitter may be a relative, softens the impact by only a little.

Herein is the beginning of the break-up of the family. After a heavy day's work, the male parent comes home hopefully to relax with his beer and sports. The female parent, also tired after a full day's harassment by her bureaucratic hierarchy, must now take on a "second job," just as full-time, of being a housewife. Is it any wonder that children from such homes feel more than somewhat unwanted?

What happens next is the now trend to farm these kids out at ever earlier years, to schools. Group baby-sitting, you might say. Ego competition versus one's peers in a group. And, as the child ascends (or descends) the steps of the years into the world of regular school, his working parents expect the school, its administration and its teacher staff, to be in *loco parentis:* All things to all kids.

No wonder the child becomes alienated from his parents; he hardly ever gets to know them! No wonder this child develops an adversary role vis-a-vis all adults; he has been conditioned towards it by the lack of loving and by too much regimentation and discipline. No wonder this child looks at himself as a material product of modern society, here in this world only for the purpose of filling a role or a mold; as his ego bursts forth in the teen ages, he rebels—with violence.

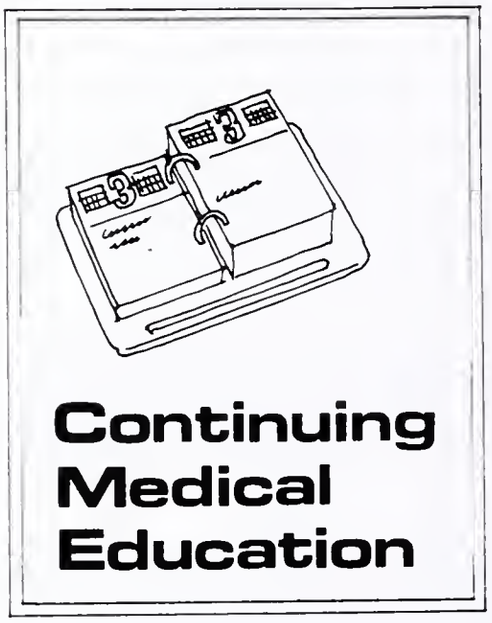
The family that has a family doctor is less likely to go down this bleak road.

Perhaps because it is a place where "things get fixed," the doctor's office can be a haven. The youngster who perceives readily that father, mother and siblings—and tutu and grandpa too—sort of all come together in one place during times of adversity and trauma and crises, and all of them "get fixed up," must surely develop a sense of true "family."

For each member of a family to go off to each his own physician, and for the kids to be "left" at a pediatrician's office—like pets left at a vet's—while Mama goes off shopping, is to follow the "farming-out" trend aforementioned: Baby-sitting again. It furthers the break-up of the family.

The family physician—the doctor who manages the medical problems of both parents, and of all the kids,—which is a role not easily taken by a minister or a church—can do a lot to keep such a family together, and, more importantly, he can help them be more respectful of each other. Respect and consideration by one man for another is the key to non-violence.

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.

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3. U.H. Cardiology Grnd. Rnds., 1st Tues. 5:30 p.m. Rm. 506 Univ. Tower, Queen's.

Kaiser Hospital
(Contact CME Dept. for further information)

Kauikeolani Children's Hospital
1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital
1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Medical Center
1. Visiting Professor Programs
2. Ophthalmology Departmental Meeting, 1st Tuesday, every month, 1:00-2:00 p.m.
3. G. I. Conference, 4th Tuesday, 8:00-9:00 a.m.
4. Medical Mortality and Morbidity Conference, Department of Medicine Meeting, 4th Tuesday, every month, 1:00-2:00 p.m.
5. Nephrology Conference, 3rd Wednesday, 8:00 a.m.
6. Oncology Conference, every Thursday, 7:30-8:30 a.m.
7. Surgical Conference, 3rd Friday, 1:00-2:00 p.m.
8. Surgical Mortality and Morbidity Conference, Department of Surgery Meeting, 4th Friday, 1:00-2:00 p.m.

(Contact: CME Dept.-Kuakini for further information)

The Queen's Medical Center
1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic
1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m.
 (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital
1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professors' Program.
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

St. Francis Hospital
1. Visiting Professor Program
2. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
3. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
4. Dept. of Medicine Monthly Mtg., 2nd Tues. ea. mnth. 7:45 a.m. UH IV Classroom.

Straub Clinic & Hospital
1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Cardiac Surgery Meeting meets the 2nd Tuesday of the month, from 4:30-5:30 p.m. in the Doctor's Dining Room.
3. Friday Noon Conference meets weekly, from 12:30-1:30 p.m., in the Doctor's Dining Room.
4. Medical Grand Rounds meets the 1st Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.
5. Orthopedic Conference meets quarterly, from 7:30-9:00 p.m., in the Doctor's Dining Room.
6. Quarterly Professional Meeting meets the 4th Monday of the month, from 7:30-8:30 p.m., in the Doctor's Dining Room.
7. Surgical Mortality and Morbidity meets the 4th Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.

Wahiawa General Hospital
1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)
1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu
Type: I, 1 hr/day, 1 day/mo from 12 mos
Fee: None Methods: AV, O, Pan
Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: I, 1 hr/day, 1 day/mo for 8 mos
Fee: None Methods: AV, Clin C, O, Pan, R
Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

Apr. 3, 7, 1978	14th Congress Pan-Pacific Surg. Assoc. Hilton Hi Village, Honolulu, HI., 7:30 a.m.-12:45 p.m.. For details write: Cesar B. de-Jesus, M.D., 236 Alex. Yng. Bldg. 1077 Bishop St., Honolulu, HI 96813. (808) 536-4911.

Apr. 16-22, 1978	Diving Medicine (General), Held at King Kamehameha Htl., Kailua-Kona, HI. 6 days-25 hrs. Cat. 1. U of HI Schl. of Med. 1960 East-West Rd. Honolulu, 96822. Contact: Dr. E. L. Beckman, Dept. of Physiology (808) 948-8652 or Harold Brown (808) 373-3745 or 3045.
Apr. 17-21, 1978	Emergency Med., 1978 at Royal Lahaina Htl., Maui, HI. 5 days-30 hrs. U of So Calif
Sept. 20-23, 1978	Genetics & the Pediatrician—What Every Ped. Should Know.—Held on Oahu & Maui. Contact: Wilma Schiner, Workshop Coord. Kapiolani-Chldrn's Hsp. 1319 Punahou St., Honolulu, HI 96826 for further info.
Oct. 1, 6, 1978	122nd HMA Annual Mtg. & AMA Regional CME Mtg. Ilikai Htl. Ala Moana Blvd., Honolulu. Contact: Mrs. Bess Chang at HMA for further info.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.





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Hawaii Academy of Family Physicians' Newsletter

J. L. Frederick Reppun, M.D.

News of Members—Nathan Wong MD, Resident Affiliate with Kaiser Hospital, attended his first Council meeting last month, as a new councillor. **David Livingston** hit the news once more in a letter-to-the-editor (SB 3/4/78), blasting Judge Robert Richardson for redefining rape as: Sex with a woman pugilist.

The Hawaii Chapter ranks among the top 21 of the AAFP in terms of the number of members dropped for lack of obtaining enough credits each three years—1% or less. Puerto Rico lost 31%, Nevada 28%; the rest lost 10% or less.

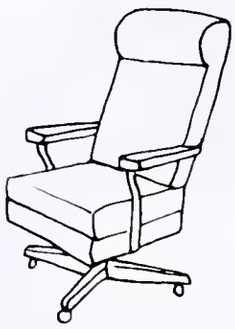
The ABFP has come up with a list of diplomates to date. Members of our chapter include: **Azman, Bade, Baysa, Bell** (Bob), **Bomgaars, Cahill, Dilcher, Dodge, Farrell, Freeman, Harrison, Hattis, Doris Jasinski, Koch, Langworthy, Livingston, L. Luke, Machigashira, McLaughlin, Miller, D. Newman, J. Newman, Padwick, Percy, Schroeder, Shlachter, Sowers, Stahl, Tesoro, Van Putten, P. Walsh, Wentworth,** and **Wigle.** 33 HAFP, 42 Hawaii total.

Committee Appointments—approved by the Council include: Constitution & By-laws: **Reppun.** Education: **Hase** and **Lafferty.** Health Care Services: **Stahl.** Legislative: **Dietrich.**

First Annual Seminar—held in January had 27 AAFP members signed up for the 2-day session, 5 non-members and 3 Resident-Affiliates. Not all attended both days, however. Guest speaker **Dan Ostergaard MD** reported that of 16,000 MD graduates, 2,000 go into Family Practice Residencies. There are now as many students interested in taking the ABFP exams as are interested in taking the other specialty boards. There are 5,400 Residents in Family Practice, the second largest group; there are ca. 10,000 in Internal Medicine and its subspecialties.

Questionnaire—Tom Cahill reports as of March 1977, with 33 responding out of ca. 70 Active members, the range of charges for an initial visit of a patient (Code 90,000 to 90015) was from $7.20 to $36, the median being $14.00, and for a follow-up visit the range was from $5.60 to $28.50 with the median being $11.00. For a routine (recheck) hospital visit the charges varied from $6 to $24 with a median of $16 (25 responded to this question). 27 of the responders said they would take on new DSSH patients. . . . Mr. Andy Chang, please note! The Conversion Factors used varied from 0.70 to 1.20 in Medicine and 7.5 to 12.9 in Surgery.

CME—Please be reminded: Pan-Pacific 1 to 7 April; "Controversies in Care," Ob-Gyn, Maui, 18-25 April; The Australians on Sunday 9 April.



Clinical Pathologist's Easy Chair

Francis Fukunaga, M.D.

Platelet Transfusions

Platelets are essential for normal hemostasis. They form the hemostatic plug in an injured blood vessel and also provide platelet factor-3 for plasma coagulation. Only a few platelets will provide adequate factor-3, but the hemostatic plug requires viable and qualitatively normal platelets. Spontaneous bleeding is unlikely when the platelet count is more than 30,000 per cubic mm.[1] The hemostatic platelet plug begins with adhesion of platelets to the injured vessel wall where they show a selective affinity for collagen fibers. The platelets undergo partial degranulation and release ADP that stimulates aggregation of additional platelets. Thrombin stimulates the morphologic and biochemical transformation of the platelet aggregate and release of the platelet factor-3. The final phase is clot retraction which requires metabolically active platelets, fibrinogen, thrombin and glucose.

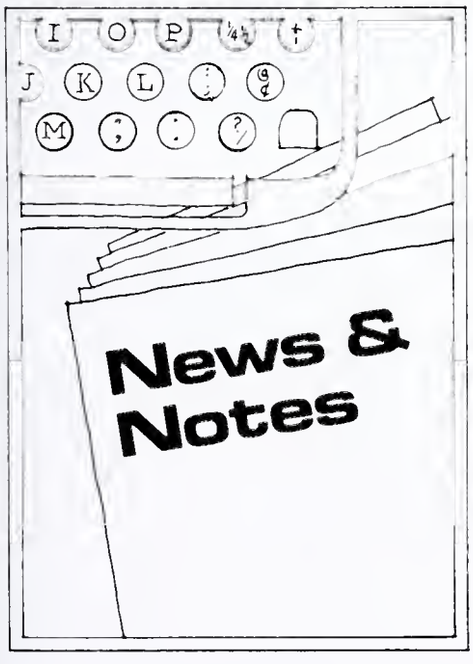
The chief indication for platelet transfusion is thrombocytopenia secondary to bone marrow failure, as in aplastic anemia and in leukemias under cytotoxic therapy, but also in the rare cases of genetically defective platelets as Glanzmann's thrombasthenia. The platelet count should be less than 20,000 per cubic mm since dangerous bleeding is rare above this level. The preferred method of platelet transfusion is with platelet concentrates that have at least 80% of the available platelets. Platelet concentrates equivalent to 4 units of whole blood can be prepared at each plasmapheresis. Transfusion should be through the special platelet filter. The normal platelet life span averages 8 days but survival of transfused platelets is erratic and transfusions may be required every 2 to 3 days. One unit of platelets per 7 kilograms of body weight raises the count at least 50,000 per cubic mm. The transfusions should be monitored with counts before, 1 hour later and on the following morning. If the count is not

increased by 1 hour and/or if there is a rapid disappearance of the platelets, one should look for an occult DIC (disseminated intravascular coagulation) or alloimmunization. Any hemorrhage or thrombosis, including occult DIC cause platelet consumption. Antibodies to HLA antigens develop in about 75% of the patients receiving repeated platelet transfusions. These antibodies cause a progressive decrease of platelet survival and some patients react with chills and fever. These individuals will eventually require HLA typing to identify compatible donors. The use of a single donor can reduce the risk of this isosensitization. A platelet aggregometer can be used for pretransfusion compatibility testing.[2]

Adults require at least 4 units of platelet concentrates at one time for effective results. Four units of fresh platelet concentrates have the equivalent effect of 12 to 16 units of stored platelets. Platelets stored up to 72 hours have an acceptable viability, but refrigerator storage reduces their life span in the recipient. Platelets should ideally be stored at 22±2°C and should be gently rocked or rotated.[3,4,5] The ABO and Rh systems do not affect platelet survival but since platelet concentrates are frequently contaminated with red blood cells, it is desirable to use ABO and Rh compatible blood, especially in young women.

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1. Sahud MA: Platelet Disorders. *Calif Med* 116:21-31, 1972.
2. Wu KK, et al: Use of Platelet Aggregometry in Selection of Compatible Platelet Donors. *New Eng J Med* 292:130-133, 1975.
3. Kunicki TJ, et al: A Study of Variables Affecting the Quality of Platelets Stored at Room Temperature. *Transfusion* 15:414-421, 1975.
4. Murphy S, Gardner FH: Room Temperature Storage of Platelets. *Transfusion* 16:2-3, 1976.
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HENRY N. YOKOYAMA, M.D.

Life in These Parts

Mistaken identity . . . It was 7 a.m. and we had just taken our first sip of coffee to remove the cobwebs when the phone rang . . . "Doc . . . Grandma's pulse is very slow . . . What should we do?" We had a 90-year-old lady in the hospital with a gastric ulcer, and severe peripheral neuropathy who had just developed a pneumothorax from cavitary pneumonitis . . . "Can you come right over?" asked the concerned voice . . . Then a brain cell started functioning . . . Why is the son calling instead of a nurse or a medical resident? "Say, is this Derek?" "No, this is Robert." With grandma's identity straightened out, instead of rushing to the hospital, we made a leisurely home call to see our 99½-year-old lady, an invalid for 25 years with a non-union hip fracture, who, while having papaya for breakfast, had gently slumped forward and died . . . She had been alert to the very end and looked ever so peaceful in death . . . The gathered family members were happy that she had died at home as per wish . . . Our younger 90-year-old grandma was holding her own . . .

Marion Melish, our local authority on Kawasaki's Disease, reported at a KCH Monday noon meeting that there have been 9 new cases in the past 2 months . . . **Herb Uemura,** KCH pathologist, insists it has no bearing on his recent 2-day visit with **Dr. Kawasaki** in Tokyo . . .

Keichi Goshi is a die hard smoker . . . During a Kuakini Patient Service Committee meeting when smoking in the hospital was being discussed, he commented, "Smoking is an indication of good health . . . I stopped smoking only when I was sick." (Keichi certainly has a point . . .)

A sight to behold and to warm our dear hearts . . . On Young Street next to the Police Station . . . a motorcycle cop busy writing tickets for all the private police cars parked on both sides of the street . . . Bless his unprejudiced heart . . .

Every year we become defensive when the DSSH releases HMSA prepared statistics with the names of physicians and dentists receiving more than $100,000 in Medicaid . . . HMA prexy **Marion Hanlon** emphasized that most of the doctors and dentists with high Medicaid payments are in areas heavily populated with welfare and low-income patients . . . "We again point out that physicians, and no doubt other health care professions, are not reimbursed equally for the services they provide and must continually face the accusations that they are getting rich off welfare."

After 4 years and $4 million in federal grants, David Boyd, director of the division of emergency medical services of the DHEW, had high praise for the level attained by Hawaii's emergency medical services program, but said, "After four years, there's nothing more we can do." He did suggest that implementation grants to help expand services to the Neighbor Islands may be applied for, but Hawaii would rank third in priority . . . Thus it seems that if the EMS is to continue its present level of competency, our State legislature will have to provide future funds and/or allow the City & County ambulances to charge a nominal fee . . .

The president of the American Hospital Association, Alexander McMahon was here for a regional conference and said that the Carter administration's bill to limit cost increases to 9% a year is "simplistic" and "assumes that all hospitals are alike—like automobiles. It just won't work because each hospital is different . . ." He feels that a rise of 13 to 14% per year is more realistic . . .

The Hospital Association of Hawaii reports that people in Hawaii are among the healthiest in the nation. The combined male and female life span in Hawaii is 73.6 years compared with the national average of 70.75 years. Moreover neonatal deaths are the lowest in the country viz 7.7 per 1,000 live births as compared to a national average of 11.6. . . .

Incredible . . . George Daacon, *Advertiser* columnist reports that a Gregg Fedderson rented a Physicians Ambulance Service ambulance "that ferried a bunch of party-goers around the town t'other night . . . The ambulance co's Larry Walter, by the way, is sorry about the whole incident and knows, of course, that anyone using an ambulance siren out of an emergency is breaking the law."

In the wake of the MMH (Maui Memorial Hospital) vs. DOH controversy, Gov George Ariyoshi authorized 34 new jobs bringing the total to 41 new positions for the year . . . Guess it pays to sound off . . .

Interesting . . . Judge Alfred Laureta of the 5th Circuit Court (Kauai) announced that "A woman can sexually abuse a man—that is, force him to have sexual contact—but it is impossible for her to rape him." Jack Annon, clinical psychologist and William Davis, urologist and senior consultant to the sexual counseling service, U of H School of

Medicine, had testified that "males are physiologically capable of being raped by forcible compulsion by women under certain circumstances or with the use of certain techniques . . ." Female attorney E. Courtney Kahr, argues that the rape charge against her client, Isidro Rivera, should be dropped because "Hawaii penal statutes dealing with rape in the State of Hawaii are the only penal statutes wherein only the male is chargeable with the crime . . . These statutes are unconstitutional pursuant to the guarantees of the 14th Amendment."

Warped sense of humor? Daacon, *Advertiser* columnist writes: "No lie: There's a doctor in Queen's Physicians Office Building named **Pill Whoon Hong** . . ." He also wrote: "Huh? On the list of doctors the golf pros can call in an emergency is **Dr. Neal Winn,** specialist in obstetrics and gynecology."

A $49,203 grant from the March of Dimes went to establish Hawaii's first comprehensive medical genetics service under Y. Edward Hsia. Hsia, an internationally noted medical geneticist who came to Hawaii from Yale University School of Medicine, is headquartered at Kapiolani-Children's Medical Center . . .

A politician to watch . . . Rep Byron Baker has introduced two measures in the House aimed at reducing the spiraling costs of health care provided to public assistance recipients. One measure calls for the creation of a Hawaii Health Service Authority which would administer a comprehensive health services program for low income and indigent persons. One major provision of the bill would **require** doctors to provide free medical services to the state under the direction of the authority. Another related bill would establish a system of medical centers as means of reducing costs in providing health care to public assistance recipients . . .

Aina Haina pediatrician **Wayne McKinny** wrote in "Speaking Out" (*Honolulu Magazine* Feb '78): "Lucky you live Hawaii? Maybe not—Because Hawaii residents are 8 to 10 times more likely to catch Salmonella than their friends and relatives on the mainland.—Why does Hawaii have the highest reported rate of human cases of Salmonellosis in the nation?" Wayne concludes that the reason is that our sanitation laws are not rigidly enforced and that jurisdiction for enforcement of the laws was transferred to the Health Department's Sanitation Branch from the Agriculture Department's Meat Inspection Branch by the 1977 Legislature. "Knowledgeable observers say the transfer was because of pressure from some slaughter houses and fast food chains . . . Until some changes are made—and existing regulations enforced more vigorously—the expression, 'Eat and Run' has a more literal meaning in Hawaii."

Mitsuo Aoki, Ph D, professor of religion at U of H conducts "death confrontation" courses for local nurses, physicians and lay men. "You got to ask the dying person what he really wants—and then you've got to listen." The dying really want to say so much, but we rarely listen and therefore we fail to do some elementary things . . . The patient asks very simple things, but what a relief to him when they are granted."

Claude Caver's Witticism . . .

If the FTC (Federal Trade Commission) insists that physicians advertise their talents and wares, Claude feels that we may generate the following ads:

"Dr Freudian Schlipp and Dr A. Nussbalm announce their association for the practice of Psychiatry and Proctology at the Odds and Ends Clinic, Inc."

"Mammopexies: Free balancing and alignment Service . . . Minor tune-ups our specialty . . . So quick . . . So easy . . . **Front End Service Clinic"**

"SATISFACTION GUARANTEED! If you are still having those disgusting acne pimples by age 75, we will cheerfully refund all your money. We have never had a patient die from acne! Our doctors *understand* teen-agers because our doctors *are* teen-agers! We squeeze your pimples only with boxing gloves on! Acnosil and Clearamel Clinic, Inc."

"GIRLS—GIRLS—GIRLS—Get your pelvics and deliveries done by our friendly, warm-hearted doctors who really care. No charge for pregnant senior citizens. Free baby luau if you have sextuplets . . . We assist you in filing paternity suits. Our latest scientifically proven miracle drug birth control method sold here. Rub it on your stomach every day and it will even cause reabsorption of an early fetus. That is why we call it: **'Absorbing Junior.' TRIMESTER OB-GYN GROUP"**

"HEALTH INSURANCE PLAN: Specially designed for college students! Lowest rates because it covers only what you need. Limited to: pregnancy, birth control, abortions, scabies, alcoholism, drug addiction, V.D., Health foods . . . **N-E-Time Health Plan"**

"PILES . . . of money are saved by people who patronize our clinic. Lowest fees in town! Pay cash and receive no bills. Deadbeats welcome! **Watergate Clinic"**

"Two for One Sale! On pneumonectomies, pay to have one lung removed—get the other one removed **FREE! Big Four Surgical Clinic."**

"FREE CIRCUMCISIONS With any castration. Go first class. Have everything removed at once. In addition, we offer free assistance in getting a job as a soprano at the Glades. **Unisex Clinic Inc."**

"Thin Hair? (Who wants fat hair?) Generous trade in on your old wigs if you have your hair transplants done here. Use your own hair and save money. **KOJAK HAIR CLINIC"**

"FREE PHYSICAL EXAMS No waiting! No removal of clothing. Our doctors have the shortest fingers in town. Share the same room with a beautiful girl! (Any diseases found will be treated at regular rates) **Lightning Service Clinic"**

"Show and Tell Our cosmetic surgeons will make you beautiful. Show your friends and tell your neighbors and receive a discount or rebate for every one you send in! **FREE**—Lifelike Halloween mask with every face lift. **TRIPLE-A CLINIC"**

(Ed.–More in next issue)

Professional Moves

The Equine Year stands for strength and endurance . . . Our beloved, durable equestrian and editor **Harry Arnold Jr** is just that sort . . . Though he was thrown by his horse and suffered a hip fracture last year, he will forego the luxury of retirement and continue in private practice at the Queen's Physician Office Building Suite 412. He is joining fellow dermatologists **Allan Izumi** and **Robert Clingan** . . . Eyeman **Shigemi Sugiki** has also moved into the Physicians' Office Building Suite 508 . . . Another Eyeman **Donald Depp** opened at Suite 280, Alexander Young Building . . . While orthopod **Gerard Dericks Jr** opened a second office in Pearl City at 98-1238 Kaahumanu St; another orthopod **Thomas Owens** joined the Honolulu Medical Group, Inc, and yet another orthopod **Martin Wolferstan** joined the Kaiser Permanente Medical Care Program at 1697 Ala Moana Boulevard (with the skateboard fad still popular, orthopods have enough to do) . . . **Gary McQueen** joined the Dickson-Bell Medical Center at 1441 Kapiolani Blvd and Internist **Gilbert Sofio** joined the Fronk Clinic . . . On the Big Island, pediatrician **Robert Laird** joined the Kona Coast Medical Group, Inc, and OB man **Allan Takase** opened his office at 670 Ponahawai St., in Hilo . . . North Kohala either has lost or is about to lose its last physician because of lack of sufficient patients . . . Rep Yoshito Takamine has introduced a bill under which the DOH would be able to contract physicians and guarantee them an annual $36,000 net income . . . **George Roger Gay** (who is both a fellow of the Academy of Family Practice and of the American college of Anes-

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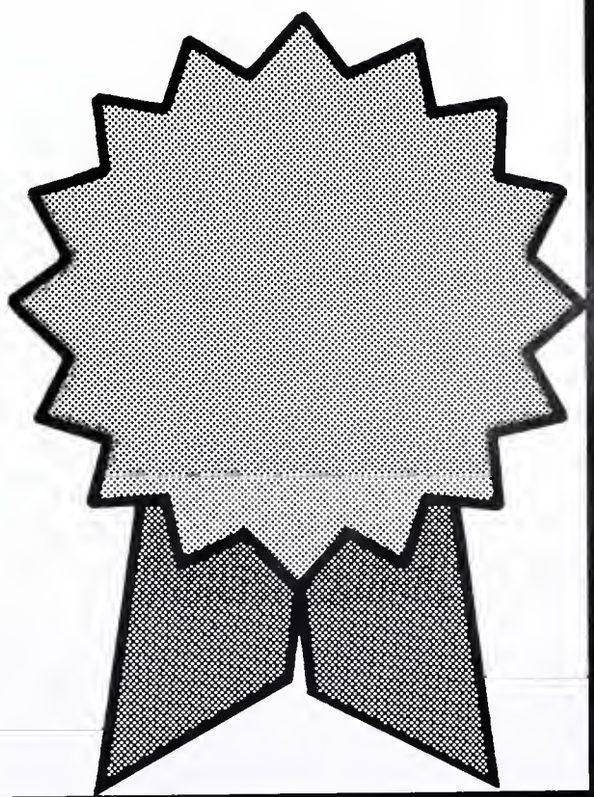
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thesiologists) and **J. Mark Sowers,** also a fellow of the Academy of Family Practice have joined the Hilo Medical Group Inc . . . On the Garden Isle, surgeon **Robert Weiner** joined the Waimea Clinic . . .

We apologize for having misplaced these announcements from August and December of last year: In August, into the Queens' Physicians' Office Building came **Joseph Brock** and **Gary Fujimoto** into Suite 905; along came **Charles Ching** into Suite 903; and endocrinologist **Werner Schroffner** into Suite 902 . . . Dermatologist **Nancy Wang Edwards** and ENT man **Kenneal Y.C. Chun** joined the Honolulu Medical Group, Inc . . . OB man **Bruce Luke** joined the Fronk Clinic Pearlridge . . . Neurologist **Hideki Kitano** and neonatologist **Kathleen A. Poon** joined the Kaiser-Permanente Medical Care Program . . . Urologist **George Kennessey** relocated to the American Security Bank Building; internist **Margaret Rose** relocated to 1481 So King Street, Room 539; and cardiologist **Richard Reeve** opened at 848 So. Beretania, Suite 315 . . .

In December, cardiologist **Coolidge Wakai** relocated to Suite 320, 1481 So King St; urologist **James Dow** opened his Aiea Branch Office at Newtown Square Building Room 322; and **Birendra Singh Huja** opened a satellite office at 98-020 Kam Highway, Waimalu Shopping Center . . .

Miscellany

"Why won't a skeleton cross the bridge?" "No guts!" (As told by **Quint Uy**)

"What do you call two morons who got caught in a church fire?" "Roasted nuts." (Another Quint Uy special)

"Why do cemeteries have a wall around them?" "Because people are dying to get in." (**Ben Higashi** heard this joke from his patient, a **Mrs O'toole**)

"What did the drowning hippie yell?" "Like help! Like help!" (A **Claude Caver** joke)

"You know how to keep readers in suspense?" . . . (Tell you next time . . .) (Another Claude Caver joke)

Elected, Honored & Appointed

On the academic front, radiotherapist **Carl W. Boyer** has been elected a medical delegate from Hawaii to the American Cancer Society's national board of directors . . . **Richard West** of Wailuku was inducted as a Fellow of the American Academy of Orthopedic Surgeons . . .

On the sports front, **Jack Scaff** was elected president of the Honolulu Marathon Association for the coming season . . . **Jerry Tucker** is a director at large . . .

On other fronts: **J. Mark Sowers** is board member and **Al Lemen,** executive director of the Maui Mental Health Association . . . The Hawaii County Medical Society unanimously approved a resolution commending **Kenneth Robert Hughes** for his efforts to improve the quality of medical care in Hawaii County. (Kenneth resigned his position as medical director of Hilo Hospital last December and charged the DOH with negligence in its administration of the hospital system . . .)

Sportsmen

Runners . . . **Owen Kaneshiro** who ran his first marathon beams proudly when recalling how he passed Marathon Clinic director and veteran runner **Jack Scaff** in the last few miles . . .

Ed Boone, another marathoner, has promised us a list of physicians who ran in the last marathon so we may still get your names . . .

Golfers . . . **Alan Luning** got his first hole-in-one on Feb 9, a Thursday afternoon, at Mid Pac CC using a No 6 iron on the 4th Hole . . . All his friends are invited to his hole-in-one party on April 6 . . . RSVP . . .

Kyuro Okazaki, a Chi Chi Rodrigues stylist and a spry 77-year-old, made his first hole-in-one on Feb 12, Sunday at Mililani Golf Course on the 16th Hole using his No 5 wood . . . thus fulfilling a life long ambition . . .

Oncology Dialogue

A 57-year-old man with Ca's of the bladder and prostate was being evaluated with **Quint Uy** as moderator . . . When preop radiation was suggested, Cancer Center clinical director **Noboru Oishi** recommended a lymphangiogram instead because radiation would mask the subsequent staging . . . Urologist **Bill Shiraki** commented: "The reliability of lymphangiograms is questionable . . . Needle biopsies are being done at MD Anderson . . . 4000 rads will sterilize the pelvis . . ." Pathologist **Grant Stemmerman** added, "The remarks about staging are true for any tumor, not only bladder tumors . . . It's like wondering whether the light in the refrigerator is on or off when the door is closed . . ."

Conference Notes . . .

"Use and Abuse of Antihypertensive Drugs" by Sheldon Sheps, Visiting Professor of Medicine from Mayo Clinic at KCH on March 6.

re Guanethidine: It interacts with everything ie, tranquilizers, antihistamines, amphetamines etc . . .

re Clonidine: It is inhibited by tricyclic and psychotropic drugs . . . Watch for withdrawal symptoms ie, a sharp rebound in blood pressure . . .

re Methyl Dopa: It can cause acute and chronic liver toxicity; drug fever, and rarely hemolytic anemia and myocarditis . . .

re Reserpine: I seldom use reserpine . . . Unlike the VA series, we have very poor response in Minnesota . . .

re Hypertensive Crisis: Drop the blood pressure slowly since the brain's auto regulatory mechanism is impaired . . .

re Motivation in Therapy: Too often a prescription signals the end of an interview, rather than the start of an alliance . . .

"Medical Management of Acute Pancreatitis" by J. Edward Berk, Prof of Medicine, UC Irvine Medical Center . . .

P—Pain
A—Arrest shock
N—Nasogastric suction
C—Correct fluid and chemical balance
R—Reduce pancreatic secretion
E—Ensure optimum cardio-respiratory function
A—Anticipate infections
S—Steroids and other special measures

re Pain: Demerol or Nerve block T1-9

re Arrest shock: Salt poor albumin 2 units/d

re Nasogastric Suction: Decreases cholecystokinin by reducing gastric juice—H2 blocking agent (Cimetidine) may replace NG suction

re Correct fluid and chemical balance: Do not induce hypoglycemia or hypocalcemia

re Reduce pancreatic secretion: NPO; NG suction or Tagamet; anticholinergic agents

re Ensure Optimum Cardio-respiratory function: tracheal tube, assist respiration; digitals; Lecithinase A

re Anticipate Infection: My colleagues may be right about not using prophylactic antibiotics . . . Ampicillin Rx?

re Steroids: Used in rare occasions and in desperation . . . "No patient should die without the benefit of steroids . . ." (A pun?)

re Other Special Measures: antitryptic agent; glucagon, peritoneal lavage . . .

re Surgery: Hyperalimentation before surgery; when ddx perforated ulcer; failure of response; pseudocyst; obstructive type jaundice: etc . . .

■

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Pingelap. On the latter island, he found that 4% of the people had leprosy, so it became a prospect for future endeavors for him. After two years in the position, he decided to take a full-time position as the only doctor on Canton Island, where he stayed for two years.

In 1955, Norman accepted a position with the Hawaii Territorial Department of Health as Chief of the Geriatrics, Cancer Control, and VD Control Branch. In this position, he was in charge of mass screening for diabetes and was active in heart disease and cancer control programs. Among other appointments which he received while with the Department of Health, he was named, in 1959, to the National Advisory Committee for the White House Conference on Aging. He was eventually appointed Chief of the Special Health Services Division of the then State Department of Health, and retired from that position in 1966.

After retirement he participated in a leprosy study, on the island of Pingelap, of a compound called DADDS, which is a long-acting form of a leprosy drug, dapsone or DDS. From his work with the South Pacific Commission, he remembered the high incidence of leprosy among the people of Pingelap and also their custom of intermarriage and maintaining relative geographic isolation. He went to the island and arranged to give DADDS to as many of the residents as possible, every 77 days, in an effort to prevent the disease among those exposed. This program was carried on for three years. Norman reported that six new cases were diagnosed at the end of the first year of the study but no new ones were found during the next two years. The study proved that the drug is an effective preventive, especially in children. Norman reflected back on this study with great satisfaction. The Pingelapese leaders gave a feast in his honor the last night he was there, because, they said, "you have brought life to Pingelap."

One of Norman's hobbies was collecting books and articles on leprosy and obtaining information for a book on the time patients lived at Kalaupapa before Father Damien arrived. He disagreed with Michener regarding the way the first patients were landed at Kalaupapa. Norman said that no one really knew what happened, but they were not thrown over board as Michener said, but taken to a landing. His collection of books and articles were left to the Hawaii Medical Library along with sufficient funds in his will to cover the cost of building a case in which to exhibit them.

In his retirement years, Norman was active in Central Union Church in Honolulu, where he served as a Deacon and as a member of several committees. On one occasion, he preached there. At the memorial service held for him, the minister said: "His goal in life was to serve the needs of others, and he was faithful to our Lord to the end of his days."

WALTER B. QUISENBERRY, M.D.

Our "Angels"

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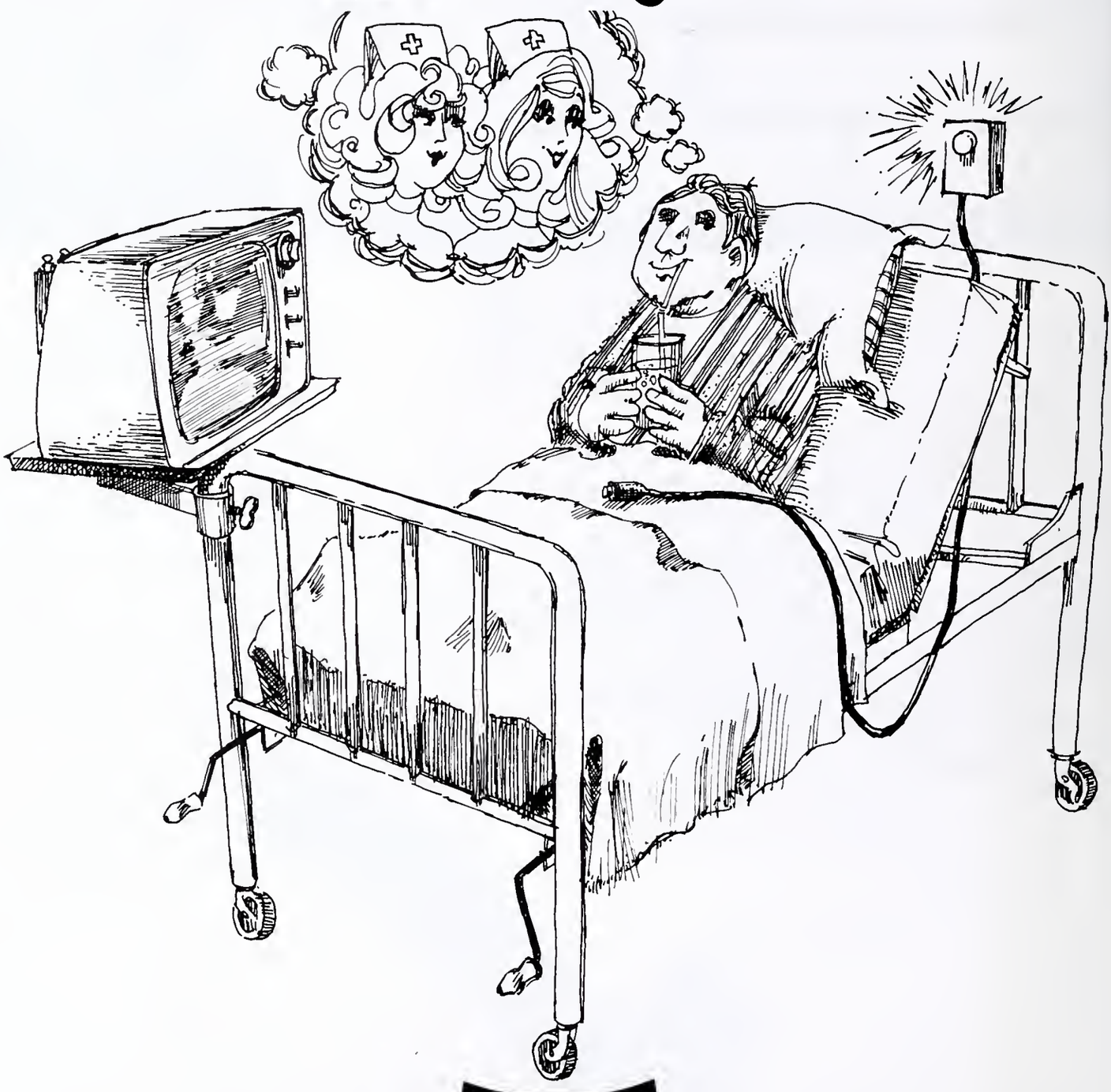
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Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,0 Persons When States Adopt Cooperating Laws–He the Measure 'Cornerstone' of His Economic Progr

WASHINGTON, Aug. 1 The Social Security Bill, p a broad program of unemp insurance and old age p and counted upon to bene 20,000,000 persons, became day when it was signed b dent Roosevelt in the pre those chiefly responsible ting it through Con s.

Mr. Roosevelt cal "the cornerstone which is being me s comple rin to

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen to

TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

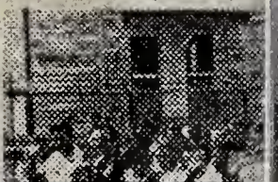
Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

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WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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Adolescent Fertility in Hawaii: Implications for Planning

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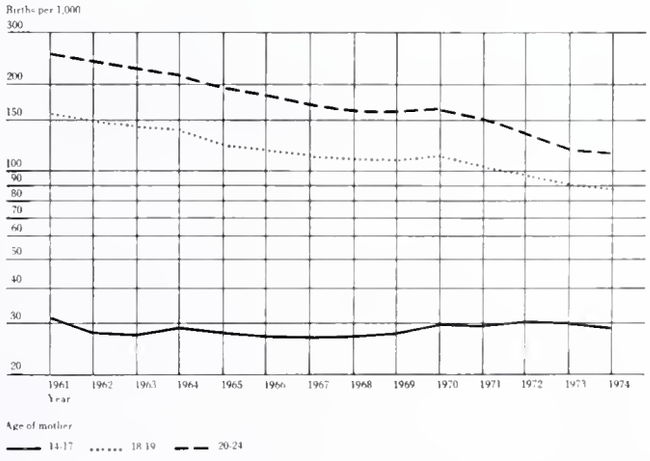
The United States has been experiencing an alarming annual rise in the number of adolescents who become pregnant.[1,2] Increasing birthrates among teenagers are in sharp contrast to decreasing birthrates noted in recent years among older women.[3] Fertility rates among adolescents in the United States are not only higher than those of other industrial countries, such as Japan and Sweden, but are also higher than those of less developed nations, such as the Philippines and East Malaysia.[4] About 10% of American teenage girls become pregnant and about 6% bear children each year. Heald[5] reported that in the years 1960 to 1967, there was a general overall reduction of 17% in live births in the total population, but there was an increase of 26% in mothers under 15 years of age and a 3.7% increase of mothers between 15 and 17 years of age.

In 1974, of the more than 11 million U.S. pregnancies among women 15-19 years of age, 27% had induced abortions and 21% were unmarried mothers. Of an additional 30,000 pregnancies reported for girls younger than 15, 45% had termination by abortion and 36% were unwed mothers.[6,7]

A 1971 study[8] reported that 94% of teenage mothers kept their babies, 2.5% sent their children to relatives or friends, and 3.5% gave their babies up for adoption. This behavior increased the need for social and economic support to an ever-increasing number of young parents, many of them single. High divorce rates were reported in a Baltimore study:[9] 3 out of 5 teenagers 17 years and younger who were pregnant at time of marriage, were separated or divorced within 6 years; this further accentuates the concern for young single parents.

Howard,[10] from her study of school-age pregnant girls, stated that girls 19 years and under, married or unmarried, white or nonwhite, are high educational, medical, and social risks. The younger the woman, the greater the risk appears to be. She reported that over 200,000 school-age girls give birth each year, and that their numbers are increasing by more than 3,000 births per year. Although 40% remain unmarried, only 15% released their babies for adoption. Counseling services were offered primarily to those who wished to give their babies up for adoption. Of those girls under age 16, 60% had another child while still of school age.

Fig. 1.—*Number of births per 1,000 females aged 14-17, 18-19 and 20-24, United States, 1961-1974*



From: "11 Million Teenagers, What Can Be Done About the Epidemic of Adolescent Pregnancies in the United States," The Alan Guttmacher Institute, Planned Parenthood Federal of America, Inc., New York, 1976.

Wallace, et al.[11] further stated that the unwed pregnant woman under 20 years of age presents serious health, social, educational, and vocational problems. They reported that live births

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to unwed mothers increased from 42,600 in 1940 to 165,700 in 1968. In 1968, half of all live births out of wedlock were in girls under 20 years of age, and 2.1% of all out of wedlock pregnancies were in girls 15 years and under.

Zackler, Andelman, and Bauer,[12] in their Chicago study of pregnant teenagers 15 years and under, found that live births to teenagers, 15 years old and under, increased from 12.0/10,000 live births in 1950 to 51.3/10,000 live births in 1966. They studied two groups of girls 15 years and under. One group (project) received prenatal care under the Chicago Board of Health, the other group (nonproject) received care outside the Board of Health. The project group's premature rate of 13.3/100 live birth was lower than the 16.6/100 live birth for the nonproject group. Neonatal deaths were also reported as follows: 18.2/1000 live births (project), 42.9/1000 live births (nonproject).

Another special concern for this younger group of girls was highlighted when Israel and Wouteresz[13] reported a toxemia incidence among pregnant girls 15 years and under as 5 times higher than that occurring in adult women.

Adults	5.0%
Under 20	11.1%
Under 17	12.6%
Under 16	18.9%
Under 14	28.5%

The low-birth-weight infant has been identified as being at special risk of suffering from many handicapping residual conditions.

Infant Mortality in Hawaii

In a study of infant mortality in Hawaii, 1966-1969, Burch[14] reported the highest infant mortality rate to be in mothers under 20 years of age.

Mother's Age	*Rate*
Under 20	27.7 per 1000 live births
20-34	16.2 per 1000 live births
35 and over	22.7 per 1000 live births

The statewide infant mortality rate was 19.2 per 1000 live births in 1969. In 1970, 13% (2165) of all births were born to mothers under 20 years old. Of the 1577 total illegitimate births, 46% were to mothers under 20 years of age. Of the 721 fetal deaths reported in 1970, 545 represented elective abortions to pregnant girls under 20 years of age.

OBJECTIVES. This study proposed to describe the characteristics of young parenthood in Hawaii from 1968 to 1972; identify special at-risk populations in Hawaii during preconception, interconception, pregnancy, and parenting; identify children of at-risk mothers; identify trends which may affect the planning, delivery, and evaluation of needed programs and services; and, determine the need for and nature of specific, modified, and innovative services to teens and preteens.

METHODOLOGY. Computer printouts of cross tabulations of selected data from the vital records for live births, infant and fetal deaths, marriages, and divorces which occurred in the State of Hawaii during 1968, 1969, 1970, 1971 and 1972 were obtained. No names or identifying data were obtained or used in the study. Age-specific data include characteristics of mothers and fathers by race, education and residence by census tract; month prenatal care began; complications of pregnancy; birth weight, and legitimacy of infants. Residency data were made more meaningful for the purposes of this study by grouping census tract data according to school districts.

Findings

LIVE BIRTHS. During the 5-year study period, 1968-1972, there were 10,189 live births to women aged 10-19 years. By year, there were 1,757 live births in 1968, 1,980 in 1969, 2,166 in 1970, 2,121 in 1971, and 2,165 in 1972. The decrease in live births in 1971 reflect the 1970 change in Hawaii's abortion law. There was a 2% increase in number of live births in 1972 over 1971.

In 1970, when there were 2,166 live births to women 10-19 years old, and when the popula-

TABLE 1.—*Total Live Births By Age And Race Of Mother 19 Years And Under, 1968-1972.*

AGE OF MOTHERS IN YEARS	ALL RACES		RACE OF MOTHER								
	NO.	PERCENT	CAUCASIAN	HAWN PART HAWN	CHINESE	FILIPINO	JAPANESE	NEGRO	SAMOAN	OTHERS	UNKNOWN
All ages	10,170		3,346	3,459	186	1,680	951	109	232	205	2
		100.0	32.9	34.0	1.8	16.5	9.4	1.1	2.3	2.0	—
11	1	—	0	1	0	0	0	0	0	0	0
12	4	0	0	2	0	1	0	0	1	0	0
13	17	0.2	2	10	0	3	2	0	0	0	0
14	104	1.0	21	45	0	22	7	2	5	2	0
15	324	3.2	73	146	6	65	21	2	7	4	0
16	893	8.8	249	365	13	167	57	5	20	17	0
17	1,668	16.4	489	598	20	310	160	8	46	36	1
18	2,892	28.4	940	966	57	475	289	42	63	60	0
19	4,267	42.0	1,572	1,326	90	637	415	50	90	86	1

tion of men and women aged 10-19 years was 151,964[15] the age-specific birth rate for live births per 1000 population was 14.2. The State rate for that year was 21.3.

Live births by age of mother provides an opportunity to look at the number and percentage of women 19 years old and under. Women 18-19 years old had 70.4% (7,159) of the live births. About 30% were to women below age 16, required by state law to be in school. A total of 126 (4.2%) of these younger women were of intermediate school age.

A closer look at live births by age and race (Table 1) shows that 11- and 12-year old mothers included 3 Hawaiians, one Filipino, and one Samoan. There were 55 Hawaiian and part-Hawaiian, 25 Filipinos, and 23 Caucasians in the 13-14-year old group who had had live births during 1968-1972. Some Japanese, Samoan, and other females were also in this group.

PREMATURITY. Prematurity, which is highly associated with mortality and developmental problems, was a disturbing index in this study. Mothers 10-14 years of age had 126 live births, and 26 (20.6%) were premature. The state prematurity rate during the study period averaged 7.8%. (Table 2) The largest number of premature births was among Hawaiians, with 58 (46%); Filipinos were next with 26 (20.6%) and Caucasians had 23 or 18.3%. In the 15-19 year group, the Hawaiians, Caucasians, and Filipinos had the largest numbers. This age group had an overall premature rate of 11% . Prematurity was also higher among illegitimate births; 17.4% in 1968 and 14.0% in 1971.

AGE OF FATHER. Of the fathers, 1,988, or 20%, were 19 years of age or less.

LEGITIMACY. The illegitimate births to young mothers 10-19 years of age in the study period increased from 85 (17.4%) in 1968 to 100 (15.9%) in 1970. They decreased to 95 (15.9%) by 1972. The percentage of prematurity to married mothers aged 10-19 during the study period was 11%, 4% higher than that of the State. These figures are an indication of the group at risk of getting late or no prenatal care.

FIRST PRENATAL VISIT. In the 1968-1972 period, the percentage of teenage mothers who initiated prenatal care in the first trimester increased from 816 (46.4%) in 1968 to 1,093 (49.1%) in 1970. However, by 1972, only 956 (44.2%) sought care in their first trimester. Women who reported first prenatal visits in the second trimester increased from 690 (39.3%) in 1968 to 913 (42.2%) in 1972. The number of women reporting first prenatal visits in the third trimester decreased from 207 (11.8%) in 1968 to 229 (10.6%) in 1972. Women who received no prenatal care remained constant at about 1%. Their prematurity rates were consistently 2 to 3 times higher than those who received prenatal care.

COMPLICATIONS. During the study period, 14.1% (247) of complications to mothers aged 10-19 years were not related to their pregnancies. Of the live births with complications, 25.1% (438) were premature.

PREVIOUS DELIVERIES. Of mothers aged 10-19 years who had live births from 1968 through 1972, 1,862, or 18.3 percent had at least one previous delivery. The annual figures showed a gradual uninterrupted increase from 1968 to 1972.

INFANT DEATHS. The number of infant deaths for mothers under 20 years old from 1968 through 1972 was 249, or 24.4 per 1000 live births. The state rate in 1972 was 17.0. Samoans had the highest rate, but Hawaiians, Caucasians, and Filipinos had largest numbers. Prematurity was a factor in 79.6% (107) of infant deaths. Unmarried mothers experienced 69 infant deaths (73.4%).

Cause of Death: Of 249 infant deaths 50.6% (126) were associated with complications of pregnancy, labor birth injury and congenital anomalies. Of the 249, 79.6% (107) were premature at time of birth.

TABLE 2.—*Live Births By Race, Age of Mother 10-19 And Prematurity, 1968-1972.*

		AGE OF MOTHER					
		10-11			15-19		
		PREMATURE [a]			PREMATURI		
RACE	TOTAL NO. BIRTHS	TOTAL	NO.	PERCENT [b]	TOTAL	NO.	PERCENT
All Races	78,240	126	26	20.6	10,044	1105	11.0
Caucasian	28,500	23	3	13.0	3,323	274	8.2
Chinese	2,732	—	—	—	186	25	13.4
Filipino	12,229	26	6	23.1	1,654	270	16.3
Hawaiian	16,804	58	12	20.7	3,401	367	10.8
Japanese	13,855	9	3	33.3	942	115	12.2
Negro	783	2	—	—	107	15	14.0
Samoan	1,567	6	1	16.7	226	18	8.0
Others	1,753	2	1	50.0	203	21	10.3
Unknown	17	—	—	—	2	—	—

Illegitimacy and Prematurity: Married women aged 10-19 years contributed 61.8% (154) of the infant deaths. Of the same 154 infant deaths, 66.2% (102) were premature. Unmarried women in the same age group accounted for 37.8% (94) of the infant deaths, and 73.4% (69) of them had been premature at the time of their birth.

First Prenatal Visit: Infant mortality reported by month of first prenatal visit showed 47.8% (119) of the women had initiated prenatal care in the first trimester. Initial prenatal care in the last trimester or none at all was the experience of 17% (48).

Previous Deliveries: Of the 249 infant deaths (1968-1972), 64.7% (161) were first deliveries; 30.5% (76) of mothers had reported one previous birth, and 3.6% (9) had had 2 or more previous deliveries.

These findings emphasize the need to identify and provide prenatal services to single young mothers who are pregnant for the first time to decrease prematurity and infant mortality.

MARRIAGES AND DIVORCES. The marriage rate of 28.9 per 1000 among 15-19 year olds was higher than the reported statewide rates of 14.8 in 1970, and 12.1 in 1972. Burch[16] reported that in 1970, 55.3% of the brides 15-18

TABLE 3.—*Marriages By Age And Race Of Bride, 1968-1972.*

RACE	AGE						RACE	AGE					
	15 YR.	16 YR.	17 YR.	18 YR.	19 YR.	TOTAL 15-19		15 YR.	16 YR.	17 YR.	18 YR.	19 YR.	TOTAL 15-19
Caucasian							Filipino						
1968	2	29	101	346	477	955	1968	3	15	36	66	77	197
1969	3	36	129	417	543	1,128	1969	3	23	52	97	89	264
1970	6	42	143	451	567	1,209	1970	5	30	50	110	100	295
1971	8	34	88	317	370	817	1971	6	28	56	121	98	309
1972		11	53	142	253	459	1972	—	21	45	97	101	264
TOTAL	19	152	514	1,673	2,210	4,568	TOTAL	17	117	239	491	465	1,329
Hawaiian							Chinese						
1968	—	2	1	7	4	14	1968	—	3	4	9	19	35
1969	—	1	1	7	5	14	1969	—	—	4	18	21	43
1970	—	1	5	13	14	33	1970	—	2	8	13	21	44
1971	—	3	4	9	7	23	1971	1	—	3	11	16	31
1972	—	2	2	5	11	20	1972	—	1	4	3	11	19
TOTAL	—	9	13	41	41	104	TOTAL	1	6	23	54	88	172
Part-Hawaiian							Korean						
1968	4	32	58	154	143	391	1968	—	2	—	6	4	12
1969	2	48	75	170	222	517	1969	—	—	2	3	7	12
1970	7	46	95	195	201	544	1970	—	1	1	5	5	12
1971	5	56	80	199	177	517	1971	—	—	2	6	2	10
1972	—	14	51	112	197	374	1972	—	—	1	3	6	10
TOTAL	18	196	359	830	940	2,343	TOTAL	—	3	6	23	24	56
Japanese							Samoan						
1968	2	8	19	58	101	188	1968	—	3	5	9	13	30
1969	1	7	28	70	101	207	1969	—	4	4	5	12	25
1970	—	11	31	77	102	221	1970	—	6	6	16	15	43
1971	1	10	24	63	105	203	1971	—	2	9	9	5	25
1972	—	3	8	40	62	113	1972	—	1	5	7	13	26
TOTAL	4	39	110	308	471	932	TOTAL	—	16	29	46	58	149
Portuguese													
1968	—	4	8	8	24	44	1968	—	3	—	11	22	36
1969	1	2	5	12	19	39	1969	1	3	2	17	13	36
1970	—	1	3	13	3	20	1970	—	2	6	21	24	53
1971	1	2	4	7	4	18	1971	—	4	4	17	14	39
1972	1	—	5	2	13	21	1972	—	—	8	9	19	36
TOTAL	3	9	25	42	63	142	TOTAL	1	12	20	75	92	200
Puerto Rican													
1968	2	6	7	13	12	40							
1969	—	5	17	25	21	68							
1970	—	3	18	23	19	63							
1971	—	3	13	20	16	52							
1972	—	4	14	9	25	52							
TOTAL	2	21	69	90	93	275							

years old were pregnant at the time they were married. Not unlike the live births, marriages increased in frequency from 1968 to 1970, and decreased from 1971 to 1972 among all races. However, Caucasians, Hawaiians and Filipinos had the largest numbers of marriages. (Table 3)

Divorces increased steadily from 1968-1972 among women 15-19 years old: 48.4% (194) among Caucasian women, 19.5% (78) among Filipino women, and 14.2% (57) among Hawaiian women. 65% of divorces to women 15-19 years old were of couples who had been married for 1 year or less at the time of their divorce. (Table 4)

RESIDENCE BY SCHOOL DISTRICTS AND BY COUNTY. The total live births to girls 10-19 years of age on Oahu steadily increased in number from 1968 to 1970, then dropped slightly in 1971 and 1972 (Table 5). School districts having fewer births in 1972 than in 1968 were Kaimuki, Roosevelt, Farrington, Radford, Aiea, Pearl City, Waialua and Kalani. Waialua had equal numbers in 1968 and 1972, with the peak year of 1971 having double the number of births of these years. Some school districts, eg, Campbell and Aiea, showed marked fluctuations, while others, such as Farrington, had only slight changes from year to year. The few schools showing a steady increase each year were Kahuku, Leilehua, Waipahu and Moanalua.

A total of 8,290 live births to 10-19-year-old mothers were reported in 1968-1972. There was a wide range among the schools, from a low of 68 in the Kaiser area to a high of 1084 at Farrington (Table 6). The live birth rate per 1000 girls in this age group ranged from 7.26 in Kaiser to 55.54 in the Nanakuli school district. The rate for Oahu was 27.9. Nanakuli, Waianae, McKinley, Farrington, Leilehua, Waialua and

TABLE 4.—*Divorce By Age And Race Of Bride, 1968-1972.*

	AGES					
RACE	15	16	17	18	19	TOTAL
ALL	1	10	32	119	240	401
Caucasian	—	3	11	64	116	194
Portuguese	—	—	1	3	6	10
Hawaiian	—	—	—	2	2	4
Part-Hawaiian	—	—	7	7	39	53
Chinese	—	—	—	1	8	9
Filipino	1	7	10	27	33	78
Japanese	—	—	—	7	16	23
Puerto-Rican	—	—	2	4	7	13
Korean	—	—	—	—	5	5
Samoan	—	—	—	1	3	4
Negro	—	—	1	—	4	5
Other	—	—	—	3	1	4

TABLE 5.—*Live Births To Mothers 10-19 Years Of Age By Year (1968-1972) And School District Of Oahu.*

HIGH SCHOOL COMPLEX	1970 FEMALE POPULATION 10-19 YR. OF AGE	LIVE BIRTHS					
		1968	1969	1970	1971	1972	TOTAL
McKinley	4260	177	178	200	219	213	987
Kaimuki	4894	129	139	137	119	114	638
Kalani	4053	37	44	42	32	27	182
Roosevelt	4879	93	117	100	118	75	503
Kaiser	1818	9	13	18	14	12	66
Farrington	5385	224	224	228	207	201	1084
Moanalua	2261	29	43	48	50	55	225
Radford	2044	19	20	16	17	12	84
Aiea	1725	48	23	44	24	23	162
Pearl City	1036	21	21	24	16	20	102
Waipahu	4841	105	110	129	148	172	664
Campbell	2224	45	70	50	58	74	297
Nanakuli	1581	75	76	101	97	90	439
Waianae	1338	48	71	67	64	77	327
Leilehua	4816	148	159	185	217	218	927
Waialua	831	22	33	41	44	22	162
Kailua	6077	132	145	156	142	134	709
Castle	4111	85	118	116	97	97	513
Kahuku	1257	28	36	49	51	54	218
Unknown	—	—	1	—	—	—	1
Total	59431	1474	1641	1751	1734	1690	8290

TABLE 6.—*Live Births, Prematurity And Infant Mortality Rates For Mothers 10-19 Years Of Age In 1968-1972 By School Districts Of Oahu.*

HIGH SCHOOL COMPLEX	1970 FEMALE POPULATION 10-19 YR. OF AGE	NO. LIVE BIRTHS	LIVE BIRTH RATE	NO. PRE-MATURES	PREMATURITY RATE (%)	NO. INFANT DEATHS	INFANT MORTALITY RATE
McKinley	4260	987	46.3	111	11.3	19	19.3
Kaimuki	4894	638	26.1	68	10.7	18	28.2
Kalani	4053	182	9.0	27	14.8	8	44.0
Roosevelt	4879	503	20.6	55	10.9	8	15.9
Kaiser	1818	66	7.3	4	6.1	0	0
Farrington	5385	1084	40.3	150	13.8	33	30.4
Moanalua	2261	225	19.9	23	10.2	5	22.2
Radford	2044	84	8.2	3	3.6	1	11.9
Aiea	1725	162	18.8	18	11.1	5	30.9
Pearl City	1036	102	19.7	12	11.8	1	9.8
Waipahu	4841	664	27.4	88	13.3	11	16.6
Campbell	2224	297	26.7	27	9.1	7	23.6
Nanakuli	1581	439	55.5	38	8.7	12	27.3
Waianae	1338	327	48.9	42	12.8	16	48.9
Leilehua	4816	927	38.5	95	10.3	19	20.5
Waialua	831	162	39.0	19	11.7	3	18.5
Kailua	6077	709	23.3	53	7.5	9	12.7
Castle	4111	513	25.0	53	10.3	6	11.7
Kahuku	1257	218	34.7	28	12.8	11	50.4
*Unknown	—	—	—	—	—	—	—
Total or Island Rate	59431	8290	27.9	914	11.0	192	23.2

*C.T. ="other" = address unknown

Kahuku had the highest rates, and Kaiser, Radford and Kalani had the lowest.

In the years 1968-1972, there were 914 premature births to girls 10-19 years of age on Oahu. This figure represents 11.0% of all live births to this age group. The range was from 3.6% (3) premature births in the Radford school district, to 13.8% (150) at Farrington, and 14.8% (27) at Kalani. Kalani, Farrington, Waipahu, Waianae and Kahuku all had prematurity rates of over 12% (Table 6). The prematurity rate for all ages in the state as a whole declined progressively from 8.4 to 7.2% in the years 1968-1972.[17] Kaiser and Radford were the only two districts with rates below the 1972 statewide rate; Kailua was only slightly above it, and Campbell and Nanakuli were only slightly above the 1968 rate.

There were 192 infant deaths (23.2 per 1000 live births) to mothers 10-19 years of age in 1968-1972 on Oahu (Table 6). This is higher than the statewide rate for mothers of all ages for these years (19.0, 19.2, 19.1, 16.0 and 17.0 respectively), but lower than the State rate of 27.1 infant deaths per 1000 live births for girls 15-19 years of age in the year 1972. It is also higher than the infant mortality rate on Maui for 10-19 year old girls in 1968-1972, but lower than those of Hawaii or Kauai.

The range was from no deaths in Kaiser school district, to 33 in Farrington, or from an infant mortality rate of 0 in Kaiser to 50.4 per 1000 live births in Kahuku. Kaiser, Pearl City, Castle, Kailua, Radford and Roosevelt all had rates under 16 deaths per 1000 live births. Kahuku, Waianae and Kalani were the three highest, all with over 40 per 1000 live births.

The total number of reported fetal deaths to women 10-19 years of age on Oahu in 1968-1972 was 2,980. There was a wide range in the frequency, with 26 in Waialua and 311 in the McKinley school district (Table 7). Of these fetal deaths, 733 were classified by the Department of Health as "C.T. = 0"; that is, the fetal death certificate listed the mother's town of residence, but gave no street address. An additional 31 were reported as "other," or address unknown. These 764 fetal deaths are not included in the present analysis by school district.

The fetal death ratio, the number of fetal deaths divided by 1000 live births, ranged from 125.3 in Nanakuli to 1030.3 in Kaiser, the highest in the State. There were 2 more reported fetal deaths than live births in the latter district. The combined ratio for Oahu was 359.5, much higher than for any other county. Kaiser, Radford and Kalani had the highest ratios, all above 500. Nanakuli, Waianae, Waialua, Leilehua, Farrington and Kahuku were lowest, with less than 200. The 3 districts with the highest fetal death ratios were the 3 with the lowest live birth and pregnancy rates. Conversely, the 6 districts with the lowest fetal death ratios were in the highest live birth and known pregnancy groups. If elective abortion is assumed to be the major factor in the different ratios, it is possible that in districts with low pregnancy rates, those girls

TABLE 7.—*Live Births, Fetal Deaths, Fetal Death Ratios[a], Known Pregnancies[b] And Pregnancy Rate Per 1000 Female Population 10-19 Years of Age[c] In 1968-1972.*

HIGH SCHOOL COMPLEX	NO. LIVE BIRTHS	NO. FETAL DEATHS	FETAL DEATH RATIO [a]	TOTAL NO. KNOWN PREGNANCIES [b]	PREGNANCY RATE [c]
McKinley	987	311	315.1	1298	60.9
Kaimuki	638	209	327.6	847	34.6
Kalani	182	130	714.3	312	15.4
Roosevelt	503	195	387.7	698	28.6
Kaiser	66	68	1030.3	134	14.7
Farrington	1084	196	180.8	1280	47.5
Moanalua	225	70	311.1	295	26.1
Radford	84	58	690.5	142	14.0
Aiea	162	40	246.9	202	23.4
Pearl City	102	41	402.0	143	27.6
Waipahu	664	149	224.4	813	33.6
Campbell	297	70	235.7	367	33.0
Nanakuli	439	55	125.3	494	62.5
Waianae	327	50	152.9	377	56.4
Leilehua	927	165	178.0	1092	45.4
Waialua	162	26	160.5	188	45.3
Kailua	709	214	301.8	923	30.4
Castle	513	129	251.5	642	31.2
Kahuku	218	40	183.5	258	41.1
C.T. = 0	—	733	—	733	—
Other	1	31	—	32	—
Total or Island Rate	8290	2980	359.5	11270	37.9

[a]Fetal deaths per 1000 live births
[b]Total live births and fetal deaths
[c]Five year total live births averaged per 1000 females 10-19 years in that district

who became pregnant terminated the pregnancy with much higher frequency than did girls in the high-pregnancy rate areas. The 3 districts with the highest fetal death ratios are also known to have a larger percentage of Caucasian women, and Caucasian women have the greatest number of abortions in Hawaii.

The total number of known pregnancies (live births plus reported fetal deaths) for girls 10-19 years of age in 1968-1972 on Oahu was 11,270, a rate of 37.9 per 1000 girls in this age group. The numerical range was from 134 in Kaiser school district, to 1,298 in McKinley. The range in rates varied from 14.0 in Radford, to 62.5 in Nanakuli, the highest in the State. Nanakuli, McKinley, Waianae, Farrington, Leilehua, Waialua and Kahuku all had rates over 40. Radford, Kaiser and Kalani remain the lowest, the only schools under 16. Radford had the lowest rate in the State. (Table 7)

Trends in pregnancy rates similar to those found in this study were presented in the Hawaii Family Planning Evaluation Annual Report of 1973-1974.[18] Both studies depict the same areas as having the highest teenage pregnancy rates on Oahu.

Tables 8, 9, and 10 indicate that Oahu recorded the highest number of live births per 1000 women 10-19 years (139.2), the highest fetal death ratio of 359.5 fetal deaths per 1000 live births, and the highest pregnancy rate of 37.9 pregnancies per 1000 women aged 10-19 years.

The island of Hawaii, with the next largest number of total live births had a comparable birth rate of 138.0, the next highest pregnancy rate of 32.9, the highest infant mortality rate of 29.9 infant deaths per 1000 live births, and the lowest fetal death ratio of 191.6. It also had the lowest prematurity rate of 10.7% among all the islands for mothers aged 10-19 years. Maui had the lowest birth rate (114.2), pregnancy rate (27.9), and infant mortality rate (16.8) but had the highest prematurity rate (12.5%). Kauai had higher rates than Maui for live birth (127.0), pregnancy (31.8), and fetal death ratio of 252.7. Kauai had second highest rates for prematurity and infant mortality, 11.3 and 24.2 respectively. The statewide rates for the same time period were a live birth rate of 20.7, a prematurity rate of 7.8%, and an infant mortality rate of 14.3.

DISCUSSION. These findings indicate specific priority needs for health, social, and educational programs and services at the state, county school district, and community levels. Further data available in the community from other sources can suggest and support many policy and program changes to establish new services, and expand and modify existing services.

TABLE 8.—*Live Births To Mothers Ages 10-19, By Island, 1968-1972.*

ISLAND	FEMALE POPULATION 10-19 YEARS OF AGE 1970	NO. LIVE BIRTHS TO FEMALES 10-19 YEARS	%	LIVE BIRTH RATE PER 1,000 FEMALES 10-19
Oahu	59,431	8,290	(82.1)	139.5
Hawaii	6,545	903	(8.9)	138.0
Maui	4,683	535	(5.3)	114.2
Kauai	2,930	372	(3.7)	127.0
Total	73,589	10,100	(100.0)	137.2

TABLE 9.—*Prematurity And Infant Mortality Rates For Mothers Aged 10-19 Years By Islands, 1968-1972.*

ISLAND	LIVE BIRTHS TO FEMALES 10-19	NO. PREMATURE BIRTHS TO FEMALES 10-19	%	PREMATURITY %	NO. INFANT DEATHS	%	INFANT MORTALITY RATE PER 1000 LIVE BIRTH
Oahu	8290	914	(81.6)	11.0	192	(81.0)	23.2
Hawaii	903	97	(8.7)	10.7	27	(11.4)	29.9
Maui	535	67	(6.0)	12.5	9	(3.8)	16.8
Kauai	372	42	(3.8)	11.3	9	(3.8)	24.2
Total	10100	1120	(100.0)	11.1	237		23.5

TABLE 10.—*Fetal Death Ratios And Pregnancy Rates For Females Aged 10-19 By Islands, 1968-1972.*

ISLAND	LIVE BIRTHS TO FEMALES 10-19	FETAL DEATHS TO FEMALES 10-19	FETAL DEATH RATIO	NO. PREGNANCIES TO FEMALES 10-19*	PREGNANCY RATE PER 1000 WOMEN 10-19 YEARS**
Oahu	8290	2980	359.5	11270	37.9
Hawaii	903	173	191.6	1076	32.9
Maui	535	118	220.6	653	27.9
Kauai	372	94	252.7	466	31.8
Total	10100	3365	333.2	13465	36.6

*Total live births and fetal deaths
**Five year total of live births averaged per 1000 females 10-19 years old in that county

TABLE 11.—*Windward Oahu Women 10-19 Years By Live Births, Fetal Deaths, Pregnancy Rate,[a] Prematurity & Infant Mortality,[b] 1968-1972.*

HIGH SCHOOL COMPLEX	LIVE BIRTH (NO.)	FETAL DEATH (NO.)	PREGNANCY RATE	PREMATURITY (%)	INFANT MORTALITY
Kahuku	218	40	41.1	12.8	50.4
Castle	513	129	31.2	10.3	11.7
Kailua	709	214	30.4	7.5	12.7
Total or Average	1,440	383	34.2	10.2	24.9

[a]Five year total of live births averaged per 1000 females 10-19 years in that district
[b]Infant deaths per 1000 lb.

Implications emerge for planning the number and kind of district and community services. For example, indices for Windward Oahu Schools, summarized in Table 11, suggest that the need for pregnancy-related services is greater in Kahuku than in Kailua, with pregnancy rates of 41.1 and 30.4, respectively. However, there are more women in Kailua in need of services, 923 compared to 258. The fetal death ratio is much higher in Kailua than in Kahuku, indicating a need for contraceptive and abortion counseling and services. The high prematurity rate of 12.8%, and Kahuku's infant mortality rate of 50.4, emphasize the need for prenatal care and early parenting support services.

In addition to grouping census tracts by school district, individual rural geographic, and socio-cultural indices should alert planners to review, separately, Waimanalo's census tract 113. The Waimanalo pregnancy rate is 40.3, slightly below the Kahuku rate, and it has a 12% prematurity rate, which compares with that of Kahuku. The significance of Waimanalo's special needs might well be overlooked, if the data were merged with the larger Kailua population.

RECOMMENDATIONS. The authors recom-

mend that the following steps be taken:

1. The data presented in this study should be used as a baseline for program and service evaluation.

2. Family life education efforts in those schools demonstrating greatest need by high pregnancy and fetal death rates should be increased. It should be coordinated with provision of added family planning services, which should be made more easily accessible and acceptable to the populations at risk. Interdisciplinary and inter-agency cooperation is essential.

3. Prenatal care, including health education and interdisciplinary health care, should be made more readily available and acceptable to young mothers in the high-priority school districts identified by high pregnancy, live birth, and infant death rates.

4. Continuing education opportunities should be increased for teachers, counselors, nurses, social workers, physicians, and others providing referral and direct services to the 10-19 year-olds in Hawaii.

5. Support services for single-parent families should be planned to meet the increasing need for such services, created by the increase in illegitimacy and divorce among the 10-19 year-old population.

6. Young women in this age group (10-19) should be involved in the service planning and evaluation processes wherever possible.

Summary

This study was performed in response to community agency requests for information with which to identify locales in need of services, to evaluate effects of their service efforts, and to develop new and innovative health education and family planning programs.

Vital records data from 1968 to 1972 were analyzed. The time period was selected to allow a review of changes resulting from the 1970 Hawaii abortion law liberalization. Age-specific data by race, education, residence by census tract, month prenatal care began, complications of pregnancy, birth weight and legitimacy were used. Emphasis was on adolescent parents. Census tracts were grouped into school districts to determine specific school populations at higher risk of specific problems. The 1970 census was used as the population base.

Findings reported by school districts showed marked differences in pregnancy rates, premature births, and infant deaths. The 3 schools with the highest fetal death and induced abortion ratios had the lowest live birth and pregnancy rates. The 6 with lowest fetal death ratios had the highest live birth and pregnancy rates.

These findings will enable planning of specific health care delivery and school health programs for school districts with the highest pregnancy, premature birth, and infant death rates.

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BLEMISHES?

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JON WON

HMA and HCMS now in the process of recruiting someone to fill a new position of Special Assistant for Public Relations. Both organizations took this position after a most welcome and needed visit, research, and report by Ms. Barbara Chapman, Associate Director, AMA Division of Public Affairs, regarding the status of community and public relations of physicians and organized medicine in the community. Basically, the report found, without exception, that the image of physicians, the HMA, and HCMS in our community is excellent; the concern was for a regular and continuing contact with the news media, health-related organizations, and the general public. This position is expected to be filled immediately.

The 1978 Hawaii State Legislative Session is over!! The bills that passed, or those that didn't, are much in line with the positions that HMA took. Such an outcome could not have been accomplished without the active and dedicated participation of the many, many physicians in meetings; to discuss positions on various bills; on development and presentation of testimony, and the countless hours of buttonholing legislators to make medicine's position known. I believe the legislators are appreciative of the time and effort spent by physicians to inform them. I want to express deepest gratitude to those physicians that took the time from their busy practices to help the HMA, as well as the medical profession, and the public, in bringing their expertise and ideas when needed. I only hope that all physicians will be able to participate in legislative matters in subsequent legislative sessions. The public needs you!!!

Emergency Medical Services Legislation has been passed by this year's legislature and has been sent to the Governor for signature. It allows the continuation of HMA-EMS' model program for the next fiscal year even though federal funding has expired. The appropriated amount has come fairly close to what was requested although the final amount authorized and released has yet to be determined.

The May 5, 1978, Council Meeting of HMA will consider any resolutions for submission to the AMA Annual Meeting House of Delegates in St. Louis, Missouri, June 17-22, 1978. Any HMA members who wish to have a resolution presented to the AMA House of Delegates—let the HMA office or any HMA Councilor know by May 5th.

Victorious Defendants Against Federal Agencies would be reimbursed for their litigation costs under a draft bill approved by the Board of Trustees. In recommending the proposal, the AMA Council on Legislation said, "The cost of defending such actions often can be staggering and can cause capitulation to agency demands even where a defense could be expected to prevail." It pointed out that several bills now before Congress would give regulatory agencies more power to require information and litigate. "With the growth of more federal agency authority, it can be expected that there will be more complex, expensive and protracted litigation in the future," the council said.

The AMA Proposal would require administrative agencies to establish reserve funds to assure payment to prevailing defendants of reasonable attorney fees and other costs directly related to defense.

The Concept of AMA Seasonal Meetings, designed to offer a wide variety of educational programs, was approved by the Board of Trustees. The proposal was prepared by the Council on Continuing Physician Education. It provides for two Seasonal Meetings each year, in addition to the Winter Scientific Meeting and the smaller Regional Meetings. The council is developing plans to work with specialty societies in programming the Seasonal Meetings.

An Appropriation of $20,000 was authorized by the Board of Trustees to help fund the National Conference on Disease Prevention July 25-27 in Washington, D.C. The conference was proposed at the AMA National Leadership Conference last January by Sen. Edward Kennedy. The conference will include programs on exercise, nutrition, immunization, drug abuse, stress, and health education in the schools and in the media.

The Conference is expected to cost about $250,000. Principal sponsors will be Kennedy and the AMA. Secondary sponsors will contrib-

ute $10,000 each and a grant from HEW will be sought to cover the balance. Total cost to the AMA, including staff travel, is estimated at $30,000.

HEW's List of Physicians Who Received Medicare Payments in 1977 "could be deceptive, expensive, and open to a significant rate of error," Rep. Thomas Luken (D-Ohio) said in a letter to Secretary Joseph Califano. The list, which is being compiled by Medicare carriers on orders of HEW, is scheduled to be available for public inspection April 30.

"*It Has Been Estimated* that this undertaking will cost the federal government from $750,000 to $1 million, and some $300,000 annually thereafter. Moreover, additional expense must be borne by the carriers, such as Blue Shield," Luken told Califano. The congressman is a member of the House Commerce Committee.

The Hazard Perry County (Kentucky) Physicians Recruitment Committee is currently seeking one orthopedist, one urologist, and one anesthesiologist. Further information from Frederick Rivara, M.D., Chairman, Search Committee, Hazard Appalachian Regional Hospital, Hazard, Kentucky 41701.



HAMPAC and AMPAC Political Contributions

There are many physicians who do not know or understand the real purpose of political monetary contributions.

The only purpose that money has in a campaign—the only role it plays—is to increase the opportunity for a candidate to tell his story to his constituents—the voters. Any restriction on the amount of money that a candidate can spend to enhance his candidacy is a limitation on the amount of information citizens will have to make intelligent decisions.

HAMPAC and AMPAC have never supported a candidate based on any commitment or any legislative proposal. To support a candidate based on a prior commitment smacks of vote buying and gives the inaccurate appearance of close ties between political effort and legislative issues. HAMPAC and AMPAC neither stipulate nor articulate a political criteria for candidates based on medical legislation. In general it can be said that HAMPAC and AMPAC support candidates who endorse the free enterprise system and constitutional government and who resist the encroachment and interference of government into the lives of its citizens.

Let's put money contributed for political action into proper perspective.

The Federal Election Commission reports that $61 million was spent for U.S. House of Representatives races in 1976. Common Cause feels that this is a horrendous amount. They call it shocking! Let's contrast this $61 million with other expenditures during the same year.

As a nation, we spent $240 million on fireworks.

We spent $276 million on hair spray.

We spent $575 million on shampoo. Of this last amount, $82.2 million was spent on "Head and Shoulders" shampoo alone. We spent more on our dandruff than we spent on candidates for the House of Representatives.

Since HAMPAC's and AMPAC's inception their respective legislative Candidate Review Committees have always made the bottom line decision on what candidates they would support and in what amount.

Recommendations for support reach the Committees from a wide variety of sources: candidates, candidate's committees, campaign managers, relatives, volunteers, colleagues and friends. But regardless of the source of a request, Candidate Review Committees explore every known source of information concerning a race. Very important sources of information are HAMPAC and AMPAC members who are active politically. Only the Candidate Review Committees can make contribution decisions for HAMPAC and AMPAC.

Now that we have provided a brief explanation of HAMPAC and AMPAC policies in their allocation of funds for candidate support, we encourage all physicians to participate in the political process by becoming 1978 active members of HAMPAC and AMPAC through their voluntary membership contribution of $20 made payable to HAMPAC. Personal checks should be mailed to HAMPAC at 320 Ward Avenue, Suite 200, Honolulu, Hawaii 96814. Contributions are not limited to the suggested amount. Neither the HMA nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of HAMPAC and AMPAC reports are filed with the Federal Election Commission and are available for pur-

chase from the Federal Election Commission, Washington D.C. Contributions are subject to the limitations of FEC Regulations Sections 110.0, 110.2 and 110.5.

Rigid and inflexible positions we don't need

At the Pan-Pacific Surgical Association 14th Congress in Waikiki (these congresses previously held every three years and to become biennial as of January 1980, are THE best of CME in Hawaii!), C. Rollins Hanlon MD, Director, American College of Surgeons, spoke out once more on his favorite theme: Surgery ought to be done by those specifically trained, and not by anyone else; surgeons should stay out of primary care. Dr. Hanlon had expressed this his unequivocal positon in the *AMA News* a couple of months ago with particular reference to the training of Family Physicians in their residencies for that specialty, as training in "simple surgery."

The breakfast panel that had on it Dr. Hanlon, the first morning of the Congress, on the subject: "Metering the Quality and Quantity of Surgical Specialists", was presented before all eleven surgical subspecialty sections in the program. The panel was moderated by Senior Surgeon Claude Welch, and it also included DHEW Internist Frederick Featherstone.

The panel agreed that an increase in the number of graduates in the specialties did not resolve the problem of adequate distribution, since such graduates tended to gravitate to the already saturated medical centers in the U.S.A. Although the number of MD graduates—15,000 in 1977—is double what it was a few years ago, the number of those specializing in surgery has declined from about 1,900 a year, to 1,200 now. The major increase has occurred in the number of graduates going into primary care.

Although there needs to be a caveat as regards a potential increase in the number of physicians who are partially and imperfectly trained in surgery, it does the country a disservice to deny people who are not in or close to urban medical centers, the expertise in surgery that can save lives or ameliorate serious sequellae from delayed treatment. A few examples come to mind: An emergency appendectomy, a tracheostomy, the insertion of chest tubes, a D & C or a C.section. Some non-emergency disabilities could also be resolved easily by appropriate surgery, without the expenditure of large amounts of time and dollars that are usually related to sending the patient to a major medical center where the top surgeons hold sway.

Both the AMA and the AAFP agree that: "A physician should be allowed to enjoy privileges to practice in his hospital commensurate with his training, skill, experience and observed capabilities," and this applies across the spectrum of medicine, surgery and obstetrics. One's peers, traditionally, have been adequate monitors of the quality of care at the local level.

For the ACS to contend that the Board certification in surgery is an adequate enough criterion of quality care, can be refuted by numerous specific instances of malpractice. Certification has been acquired time and again by applicants who have failed to perform adequately their residency training—not to mention their undergraduate work—and to pass the way-point examinations. There is no problem in documenting such instances, nationally as well as locally.

Some of the best surgeons are those with prior experience in general practice. A generalist is one who invariably treats the body and mind of the whole (entire) patient. This also contravenes Dr. Hanlon's contention that a surgeon should stay out of primary care. The surgeon who does general practice may be undesireable to the ACS, but he is welcomed by his community of patients. The caveat here is that he may, therefore, do certain surgical procedures so infrequently, as to "lose his touch."

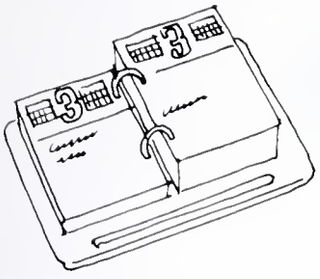
The entire practice of medicine in modern times is so fraught with the possibility of doing harm rather than good, that we need to train physicians to be physicians first, and specialists second. Surgical skills as such are no more difficult to learn than medical skills. A psychiatrist, as an MD, needs to know the basics of how to deliver a baby, or to do CPR, or to prevent exsanguination.

We trust the American College of Surgeons is not generally as rigid in its thinking as its Director!

J.I.F.R.



"BESIDES STATE AID, FOUNDATION GRANTS, AND PHILANTHROPIC DONATIONS, DOES ANYONE KNOW HOW WE CAN RAISE A FEW BUCKS?"



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.
2. Gynecologic Tutor Oncologist, James Nelson, M.D., Harvard School of Medicine; at various hospitals on Oahu from May 22-29; Kauai—May 30; Maui—May 31; Hawaii—June 1.
3. Tutor Oncologist, Seymoure H. Levitt, M.D., Radiotherapist Univ. of Minnesota; at various Oahu hospitals from June 19-24; Kauai—June 26; Hawaii—June 27; Maui—June 28.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
3. U.H. Cardiology Grnd. Rnds., 1st Tues. 5:30 p.m. Rm. 506 Univ. Tower, Queen's.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Medical Center

1. Visiting Professor Programs
2. Ophthalmology Departmental Meeting, 1st Tuesday, every month, 1:00-2:00 p.m.
3. G. I. Conference, 4th Tuesday, 8:00-9:00 a.m.
4. Medical Mortality and Morbidity Conference, Department of Medicine Meeting, 4th Tuesday, every month, 1:00-2:00 p.m.
5. Nephrology Conference, 3rd Wednesday, 8:00 a.m.
6. Oncology Conference, every Thursday, 7:30-8:30 a.m.
7. Surgical Conference, 3rd Friday, 1:00-2:00 p.m.
8. Surgical Mortality and Morbidity Conference, Department of Surgery Meeting, 4th Friday, 1:00-2:00 p.m.

(Contact: CME Dept.-Kuakini for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditiorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
3. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
4. Dept. of Medicine Monthly Mtg., 2nd Tues. ea. mnth. 7:45 a.m. UH IV Classroom.

Straub Clinic & Hospital

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Cardiac Surgery Meeting meets the 2nd Tuesday of the month, from 4:30-5:30 p.m. in the Doctor's Dining Room.
3. Friday Noon Conference meets weekly, from 12:30-1:30 p.m., in the Doctor's Dining Room.
4. Medical Grand Rounds meets the 1st Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.
5. Orthopedic Conference meets quarterly, from 7:30-9:00 p.m., in the Doctor's Dining Room.

6. Quarterly Professional Meeting meets the 4th Monday of the month, from 7:30-8:30 p.m., in the Doctor's Dining Room.
7. Surgical Mortality and Morbidity meets the 4th Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu
Type: I, 1 hr/day, 1 day/mo from 12 mos
Fee: None Methods: AV, O, Pan
Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: I, 1 hr/day, 1 day/mo for 8 mos
Fee: None Methods: AV, Clin C, O, Pan, R
Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

May 13-20, 1978	USC School of Medicine-Pediatric Workshops, Royal Lahaina, Contact Peter Millati, Exec. Dir., Fitzpatrick Travel Service, 8622 Sunset Blvd., LA, CA. 90069.
May 24-25, 1978	Toward Comprehensive Care of Uterine Cancer: An Interdisciplinary Conference, Ala Moana Hotel. Contact Kay Van Sant, American Cancer Society, 536-2031.
June 23, 1978	Toward Comprehensive Lung Cancer Care: An Interdisciplinary Conference, Ala Moana Hotel, contact Kay Van Sant, American Cancer Society, 536-2031.
July 1-8, 1978	USC School of Medicine—Manipulative Medicine, Mauna Kea Beach Hotel, contact Peter Millati, Fitzpatrick Travel Service.
August 5-12, 1978	USC School of Medicine-Ophthalmology, Mauna Kea Beach Hotel, contact Peter Millati, Fitzpatrick Travel Service.
August 12-19, 1978	USC School of Medicine post graduate refresher course, Sheraton Waikiki, Peter Millati, Fitzpatrick Travel Service.
Sept. 20-23, 1978	Genetics & the Pediatrician—What Every Ped. Should Know.—Held on Oahu & Maui. Contact: Wilma Schiner, Workshop Coord. Kapiolani-Childrn's Hsp. 1319 Punahou St., Honolulu, HI 96826 for further info.
Oct. 1, 6, 1978	122nd HMA Annual Mtg. & AMA Regional CME Mtg. Ilikai Htl. Ala Moana Blvd., Honolulu. Contact: Mrs. Bess Chang at HMA for further info.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



Friday, February 3, 1978
5:30 p.m.
HMA Conference Room

PRESENT

Drs. Marion Hanlon, George Goto, Calvin Sia, Douglas Bell, Herbert Chinn, William Iaconetti, Patrick Walsh, Russell Stodd, James Williams, Thatcher Magoun, Rowlin Lichter, John Edwards, Arnold Siemsen, Leonard Howard, Alexander Roth, Felix Lafferty, Denis Fu, Peter Kim, Arch Wigle, and Phil McNamee, Roy Kuboyama, William Dang, Donald Char, Ann Catts, Nadine Bruce, and Grover Batten. Also present was Mrs. Dorothy Sheperd.

EXCUSED

Drs. William Hindle, Neal Winn, George Mills.

CALL TO ORDER

The meeting was called to order at 5:30 p.m. by President Hanlon.

MINUTES

The minutes of the meeting of January 6, 1978 were discussed. A correction was noted in Section F relating to Emergency Medical Services and the minutes were amended to note that correction. The minutes were approved as corrected.

TREASURER

Mr. Won presented the Treasurer's report for the year ending December 1977. The Treasurer's report was approved subject to audit.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. Continuing Medical Education: Dr. Bruce reviewed a proposed letter to HMA members and non-members regarding the recordkeeping system which has been established at HMA. The CME Committee proposes that there be no charge for CME reports for HMA members but recommends that a fee of $10.00 be charged for non-HMA members who request a copy of their records.

ACTION:
It was voted to approve the recommendation.

B. EMS: Dr. Dang reviewed the legislative proposals being introduced by the HMA-EMS program. The legislation proposed will (1) give authority to the Department of Health to develop a Statewide EMS System, (2) request that the Revisor of Statutes review all sections of the law pertaining to EMS for clarification and codification, (3) give authority to the DOH to monitor, evaluate, and set rules and regulations

so that the entire EMS system will be integrated, (4) delete section 16-14 of the law which requires the counties to provide free ambulance service, (5) add a section to the law which will require the DOH to contract for certain specified services with a private, non-profit, medical organization, (6) request completion of the Medicom system and implement the "911" emergency telephone number on the neighbor islands, (7) ask that the HMA-EMS program be continued until a permanent source of funding is available, (8) provide funds for travel and per diem expenses for neighbor island trainees, (9) ask that the authority for certification and regulation of emergency ambulance care personnel rest with the Board of Medical Examiners, (10) set up a CPR project and first aid training program for all public safety employees and others as designated, and (11) set up an interim legislative committee composed of the House and Senate health committees to monitor and evaluate the program progress in the coming year. The Council was asked to approve a request to retain Attorney Richard Quinn for EMS hearing procedures. The Council agreed that the project director be given the authority to contract for legal services as needed. Bills for payment of services for legal services were approved for payment.

C. Public Affairs: Dr. McNamee reported that Tel-Med services have now been expanded to the neighbor islands. Calls can be placed at no charge between the hours of 12 noon to 8:00 p.m. on the following lines: Oahu 521-0711, Maui 244-0911, Kauai 245-9011, and Hawaii 935-0511. The HMA/HNA Public Forum on Coping with Cancer is scheduled for February 6.

D. Auxiliary: Mrs. Sheperd reported that the Auxiliary plans a workshop in late May on communication. They plan a workshop in February on Biofeedback.

E. Community Health: Dr. Char reported that the first draft of the State Health Plan has been received and that hearings are scheduled throughout February. It is expected that the 2nd draft will be prepared by March 1. Dr. Char noted that copies have been circulated to appropriate specialty societies and HMA committee members and it is hoped that comments will be forwarded to SHPDA. Dr. Sia noted that PL 93-641 is coming up for amendments this year and he noted that it is important to communicate to the AMA or to Congress any recommendations for amendment.

F. Fee Survey: Dr. Hanlon reported that the Fee Survey Committee is nearly finished with their review of the Relative Value Studies and will soon make a recommendation to the Council regarding publication. The Council asked that legal counsel be prepared to present a legal opinion and that we obtain information on the experiences faced in other states.

G. Other: The School of Medicine has requested that HMA participate in a conference to be held on Molokai in late May and that they contribute $750 toward the conference costs.

ACTION:
It was voted to table this request until further information on the program can be obtained.

H. Cancer Center: At the last Council meeting, it was voted to defer action on participation in the CCH for one month. Dr. Hanlon reported on the meetings he had attended since that time with representatives from the CCH Executive Committee and Dr. Matsuda. He also met with Dean McKaughan regarding the submission of the CORE Center Grant on February 1. Dr. Chinn presented a report on the CCH Executive Committee meeting with Dean McKaughan and indicated the changes in the table of organization that was submitted to NCI.

ACTION:
A motion was made and seconded to write to Dr. Matsuda stating that the HMA Council reaffirmed its concern for the care of cancer patients and cancer research in the community and that the Council is disturbed that at recent meetings and in the revision of the CORE grant, the functions and organization of the CCH Executive Committee that had been previously outlined in letters to the HMA dated July 31, 1974 and reaffirmed on June 28, 1977 and in meetings held between the UH, HMA, Hospital Association, ACS, and Department of Health, had been abrogated. In light of these developments, it was agreed that HMA could not support the present situation and thus can no longer participate in the activities of the CCH. The motion was passed unanimously. Copies of the letter will be sent to the ACS and Hospital Association.

I. Legislation: Dr. Howard reviewed the areas of primary interest to HMA which are being followed by the Legislative Committee: (1) Emergency Medical Services, (2) A permanent statewide school health program, (3) a bill which will permit generic substitution under certain conditions, (4) a bill which will pay members of the medical conciliation panels, (5) fraud and abuse provisions under Medicaid, (6) various bills on substance abuse, marijuana, (7) various bills relating to child abuse, sex abuse, wife abuse. Dr. Howard also noted that meetings are held every Monday evening at 5:30 p.m. and they are open to anyone who wishes to attend.

J. Peer Review: Dr. Hanlon reported that he had met with a representative from the Attorney General's office to discuss HMA's assistance in reviewing medical practice. He suggested that HMA might contact the specialty societies and ask that they nominate several representatives from whom a panel can be selected.

NEW BUSINESS

Chamber of Commerce Membership: Mr. Won asked whether the Council wished to become members of the Chamber of Commerce in 1978.

ACTION:
It was voted to continue membership in the Chamber of Commerce in 1978.

ADJOURNMENT

The meeting adjourned at 10:00 p.m.

Douglas B. Bell II, M.D.

Friday, March 3, 1978
5:30 p.m.
HMA Conference Room

PRESENT

Drs. Marion Hanlon, George Goto, Calvin Sia, Douglas Bell, Herbert Chinn, William Iaconetti, George Mills, Russell Stodd, James Williams, Rex Couch, Rowlin Lichter, Calvin Kam, John Edwards, Arnold Siemsen, Leonard Howard, Alex Roth, Felix Lafferty, Neal Winn, Denis Fu, Arch Wigle and Mrs. Dorothy Sheperd, Philip McNamee, William Dang, Donald Char, Nadine Bruce, Grover Batten, and Roy Kubovama.

EXCUSED

Drs. William Hindle, Ann Catts.

ABSENT

Drs. Patrick Walsh, Peter Kim.

MINUTES

The minutes of the February 3, 1978 Council meeting were approved as circulated.

SECRETARY

The report of the secretary indicated the total HMA membership as of January 1, 1978 was 922 members.

TREASURER

Mr. Won reviewed the treasurer's report for the period ending January 31, 1978.

ACTION:
It was voted to approve the financial statement for January 31, 1978 subject to audit.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. Medical Education: Dr. Bruce reported that the CME Committee is in the process of setting up an HMA CME award which will be issued annually to those who wish to apply. The committee recommends that the award be processed at no charge to HMA members but that a fee of $10.00 be charged to non-members who wish to obtain the HMA award.

ACTION:

It was voted to approve the recommendation to charge a $10.00 fee to non-HMA members who apply for the HMA Annual CME Award.

B. Cancer: A copy of a report to the Board of Directors of the American Cancer Society was distributed to Council. Dr. Hanlon recommended that any action regarding the report be deferred until he has met with Mr. Wheeler of ACS.

ACTION:

A motion was made and seconded to defer any action regarding the Cancer Center of Hawaii and cancer-related activities until the next Council meeting. The motion was approved.

C. Mabel Smyth Board: Dr. Batten reported that the Hawaii Nurses Association plans to move from the Mabel Smyth Building into new quarters and that they are interested in terminating the tri-party agreement (HMA, HNA, and Queen's Medical Center) for operation of the Mabel Smyth Building. The Mabel Smyth Board met and agreed to terminate the contract and to transfer the ownership of the Nurses and Physicians Exchange. There are certain fees and documents required prior to the termination of the agreement and Mr. V. Thomas Rice has been asked to review the documents.

ACTION:

A motion was made and seconded to dissolve the tri-party agreement with the Hawaii Nurses Association and the Queen's Medical Center and to authorize the HMA president to sign the necessary documents when approved by legal counsel.

A question was raised regarding the future use of the Mabel Smyth Auditorium for medical association activities. This will be explored further.

D. Legislation: Dr. Siemsen reported that a bill defining death will probably be enacted by the Hawaii State Legislature. The HMA has voiced opposition to naming physicians by specialty who may certify death and rather has suggested that any consulting physician licensed to practice medicine under Chapter 453 HRS be permitted to make the determination. This section of the bill is still being debated.

Dr. Siemsen reported that the Legislature is also considering the establishment of a commission which would serve as a counseling forum for patients. It was asked whether the Legislature would provide funds to the HMA for the commission. Dr. Siemsen noted that this was a possibility. It was noted that there is some division of HMA members on this subject as some believe the commission should be in the HMA and others believe it is the responsibility of society to share in counseling decisions.

Dr. Kuboyama reported that the School Health Bill is moving but that the Senate and the House versions are still far apart.

Dr. Howard reported that several measures have been shelved for the session including marijuana research and rubella testing. Other areas of interest to HMA are a Medicaid Fraud and Abuse section, a bill on second opinions for elective surgery, a bill calling for a study of HMOs, a bill which would decriminalize marijuana, two bills which would reduce the period of quarantine for dogs and cats, a bill which would establish community health centers.

E. EMS: Dr. Dang reported that the bills relating to the EMS program are proceeding through the committee hearings in the Legislature. These bills include SB 2387 which appropriates funds to the HMA to maintain the EMS program through the end of 1978, SB 2386 which is an omnibus bill, SB 2382 which provides per diem for neighbor island trainees to come to Oahu, and a bill which will complete the Medicom system and expand the 911 number.

F. Public Affairs: The Public Affairs Committee has prepared a model publicity code for physicians and a newspaper announcement policy for Council approval.

ACTION:

A motion was made and seconded to amend the publicity code item 10 as follows: Violations of these codes and principles will be subject to review and action by the Peer Review Committee of the county medical societies and action such as censureship may be taken by the respective societies and that this document be sent to the AMA for their comments. The motion was defeated.

A motion was made and seconded to accept the codes as a guideline for members and to eliminate item 10 of the publicity code and modify section 4(a) of the newspaper code to read "The names of physicians should be indicated by "M.D." or "D.O." and not "Dr." Specialty training and qualifications within a specialty (board eligible or board certified) and alphabetical qualifications may be employed but membership in professional organizations should not be mentioned." The motion was passed with one opposed. The codes as adopted by the Council are reprinted below.

Adopted by HMA Council 3/3/78

Newspaper Announcement Policy

1. SIZE:
 The announcements should be not more than two columns wide and its depth be limited to two inches with an allowance of an additional inch of space if needed for additional names of physicians.
2. SIZE AND STYLE OF TYPE:
 The type used should not be larger than 20 point with a relatively plain font. No ornamentation other than a simple "border" should be used.
3. ACCEPTABLE REASONS FOR ANNOUNCEMENTS:
 a) Establishing a new practice.
 b) Resumption of practice after a prolonged absence.
 c) Change of address.
 d) Change of type of practice.
 e) Discontinuance of practice due to illness or other reasons.
4. CONTENTS:
 a) The names of physicians should be indicated by "M.D." or "D.O." and not "Dr." Specialty training and qualifications within a specialty (i.e. board eligible or board certified) and alphabetical qualifications may be employed but membership in professional organizations should not be mentioned.
 b) The notice should be worded so that the announcement is made by the individual doctor and not the clinic, group, partner or associate. An announcement may be made in favor of a group only when it applies to the organization as a whole; for example, establishment of a new clinic, change of name, change of address, etc.
 c) Specialty listing should be designated by the phrase "practice limited to" rather than "specialists" or "specialty."
 d) Physicians opening or relocating branch offices may announce such opening or relocation and may state that the other office remains at the same location.

e) The address, telephone numbers and office hours may be mentioned in the announcements.

5. SCHEDULE OF INSERTION OF ANNOUNCEMENTS:
All announcements will be handled through the office of the Executive Secretary. The announcements may appear in any of the local newspapers for a period of not longer than one week. If more than one newspaper is used, all announcements should run concurrently over this one week period.
6. Congratulatory announcements to doctors, groups, clinics, partnerships, etc., by others should be discouraged.
7. It is proper for an MD in announcing his association to list the names of MD's with whom he is associating if there is no group name.

Adopted by HMA Council 3/3/78

Publicity Code for Physicians

The Hawaii Medical Association recognizes that good public relations is vital and possible only through the active cooperation of physicians with the news media. To this end, physicians should be willing to appear on television, radio and in the press whenever called upon, in accordance with the following general principles:

1. A physician should reply frankly and openly, when contacted by the news media for comment or information, provided the subject is within his jurisdiction, cognizance and specialty; otherwise he should refer the media to the proper authority on the subject.
2. News media appearances may be made in connection with scientific meetings, medical happenings, and legitimate medical procedures of public interest.
3. News media appearances for the obvious purpose of self-aggrandizement or self-publicity are inappropriate.
4. The physician may be identified by name, specialty, organizational membership, educational background and institutional affiliation; but should not be identified with any unique or special procedure, treatment, skill, or results or other self-laudatory information.
5. The physician should stress joint, rather than personal effort, in any news media appearances; and endorse only those drugs, treatments or procedures which are generally acceptable to the profession. He should not claim special skills, procedures or treatments; neither should he claim more skilled or conscientious care or better results than his colleagues.
6. The physician may release to the news media the results of his research or experiments provided it has been reported to and accepted by an appropriate national or regional medical organization, or accepted for publication by a national or regional medical journal of repute.
7. A physician should not permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, he should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises.
8. The physician's identification should be kept to a minimum in news media appearances in connection with non-medical newsworthy events.
9. The physician should consult with or clear through the appropriate committee of the medical society, the executive director or president of the society, whenever news releases of import to the medical society are planned.

The Public Affairs Committee has also considered a public relations program for the Association and has interviewed representatives of two public relations agencies to discuss what might be possible. Dr. Mills reported that the AMA has created a Department of Public Relations and suggested that an invitation be extended to the AMA to visit Hawaii to review ways in which the AMA might assist in this program. Ms. Barbara Chapman, Associate Director of Public Relations, has agreed to visit with HMA beginning March 14.

ACTION:
It was moved and seconded that the HMA President be authorized to join with the Honolulu County Medical Society in sharing the expense to research a PR program ($500.00) and allow him to make that decision after meeting with the AMA representative instead of waiting until the next Council meeting. It was recommended that Barbara Chapman meet with local consultants while she is here. The motion was carried 11 for, 9 against.

G. Community Health: Dr. Char reviewed the schedule of hearings planned to review the State Health Plan. Draft 2 of the State Health Plan is expected to be distributed on March 10 and will be distributed to members of the Community Health Committee. An open meeting on draft 2 will be held on March 20 and it is hoped that as many physicians as possible will attend this meeting.

ACTION:
A motion was made and seconded to invite a minimum of two persons from each neighbor island to attend the March 20 meeting. The motion was approved.

It was further voted to authorize the executive Committee to prepare the testimony for the public hearings.

H. Fee Survey: The Fee Survey Committee reported that it has nearly completed its work on the proposed 1978 Current Procedure and Terminology Manual and asked for Council permission to proceed with the publication.

ACTION:
A motion was made and seconded to approve the recommendation of the committee.

I. Auxiliary: Mrs. Shepard reported that the Auxiliary meeting in February was quite successful and that 11 people from the neighbor islands attended. The auxiliary is presently rewriting the bylaws.

REPORTS OF THE COUNTY MEDICAL SOCIETIES

Dr. Couch reported that at the last meeting of the Kauai County Medical Society there were 27 members in attendance to discuss the first draft of the State Health Plan. It is hoped that the society will become more active in the coming year.

Dr. Stodd reported that some of the problems between the hospital and DOH have improved somewhat.

Dr. Williams requested that the HMA assist in the development of a standard disability form. He noted the problems that physicians face in processing the different types of TDI forms.

UNFINISHED BUSINESS

Ad Hoc Committee on Self Insurance: Dr. Edwards reported that the Self-Insurance Committee had met the night before the Council meeting and at this time feels that HMA should probably go ahead with forming its own insurance company. The committee is awaiting a consultation from an insurance

consultant and expects to present their proposal at the next Council meeting.

NEW BUSINESS

A. PSRO Contract: A copy of a proposed contract for sharing services, office space, and resources with the PSRO was presented for Council review.

ACTION:

It was voted to approve the concepts outlined in the proposed PSRO contract with HMA.

B. AMA Regional Meeting: Drs. Chinn, Goto and Mills and Mr. Won attended the AMA Regional Meeting in San Francisco on March 1. A copy of several of the papers on the voluntary cost containment program, on AMA membership, and the National Commission on Cost Containment were circulated to members of the Council.

C. Policy Statement re Guidelines for Medical Society Staff Alcoholism Program: Mr. Won reviewed a proposed policy statement from the American Association of Medical Society Executives to help rehabilitate medical society staff who might need assistance in an alcoholism program.

ACTION:

It was voted to adopt the policy statement proposed.

D. Request from AMSA: A letter was received from the President of the American Medical Student Association Chapter at the University of Hawaii requesting assistance in sending medical students to the AMSA National Convention.

ACTION:

It was voted to request the Bylaws Committee to report to the Council the appropriate mechanism that could be utilized to have a representative from the American Medical Student Association and the Intern and Resident Association to sit on the HMA Council and House of Delegates.

It was further voted to approve a $500 contribution to the AMSA for 1978.

E. HMA Retirement Plan: Mr. Rice reviewed two proposed changes to the HMA Retirement Plan. It was voted to approve the recommended changes.

F. Request for HMA Rosters: A request to provide five copies of the 1977 HMA Roster to the Senior Centers was approved by Council.

ADJOURNMENT

The Council adjourned at 10:00 p.m.

DOUGLAS B. BELL II, M.D.

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WE SHOW YOU HOW TO MAKE YOUR PERSONNEL EMPLOYMENT PROBLEMS DISAPPEAR?

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Director
Medical Division

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Current Medical Diagnosis and Treatment

By Marcus A. Krupp and Milton J. Chatton. 1098 pp. Ed. 16. Lange, Los Altos, CA 94022 1978. Price, $17.

Doctor, no better bargain in an up-to-date text on general medicine can be found anywhere. This classic, annually revised, 1,098-page paperback volume is available, each year, in English, Spanish, Italian, German, Serbo-Croatian, Portuguese, and Japanese translations. Stephanie Jablonska says it's out in Polish, too.

Though the editors/authors are themselves from Stanford, they have assembled a faculty from UC (San Francisco, mainly; one from San Diego), the University of Oregon (Ralph Benson), the University of Washington (Robert Dreisbach), the University of Arizona (Sydney Salmon), and one or two other places. Ernest Jawetz and Moses Grossman still do the four chapters on infectious diseases (viral and rickettsial, bacterial, and spirochetal) and the excellent chapter on antimicrobial therapy, which alone is worth the price of the book.

Also worth the price of the book, all by itself, is the condensed and streamlined, but complete and up-to-date, textbook of dermatology contained in Chapter Three, by Rees B. Rees, Jr., former chairman of the dermatology department at the University of California in San Francisco and one of the top dermatologists of this or any other country. His discussions are concise, eminently practical, and sound. Each is prefaced with a handful of diagnostic clues whereby to identify the skin disease; each tells you just how to try treating it. Scores of formulations are given.

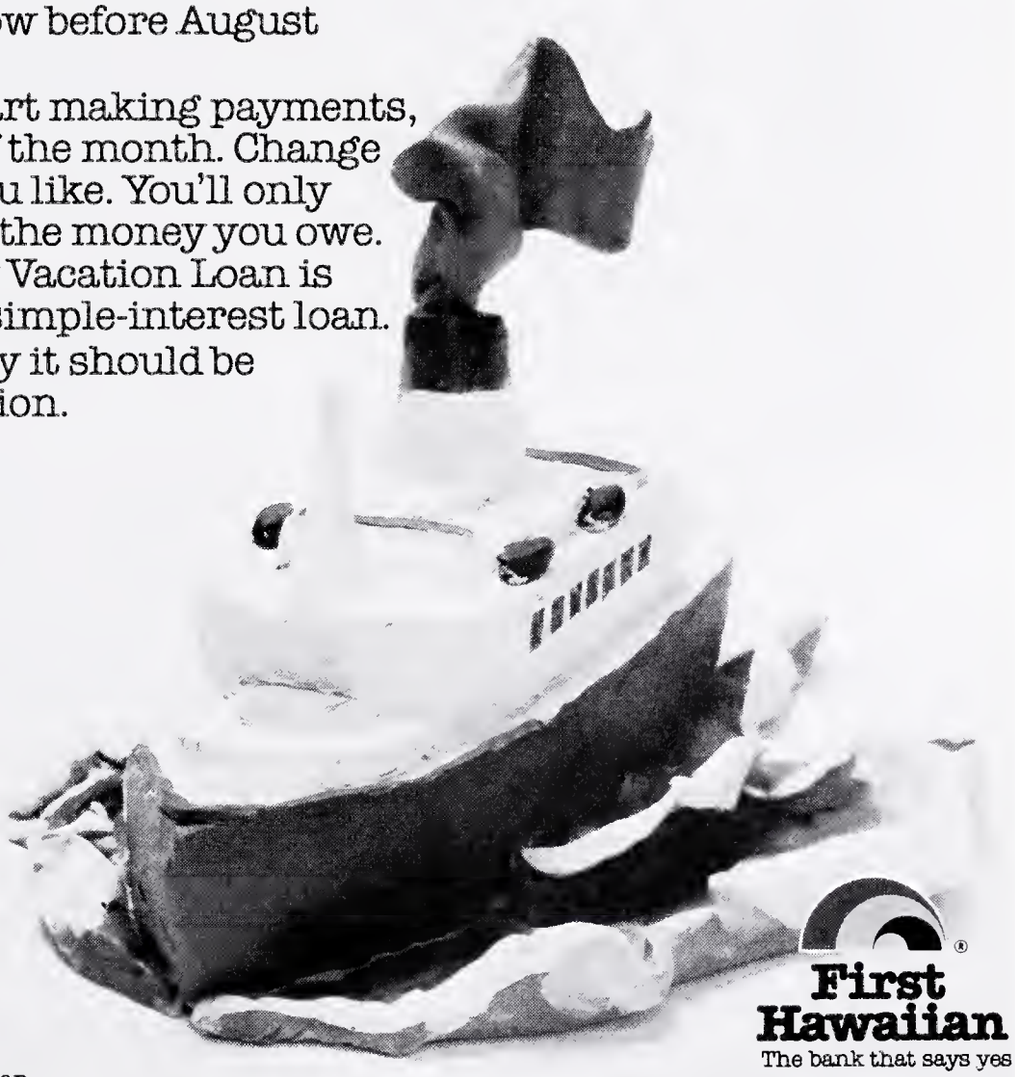
For your two-week vacation try First Hawaiian's 90-day cruise.

A PayAnyDay® Vacation Loan lets you sail for three months before your first payment is due.

Need a little vacation money for your little vacation? Try a PayAnyDay Loan from First Hawaiian. You'll get your vacation, your vacation money, and more. You'll also get a 90-day vacation from vacation loan payments if you borrow before August 31, 1978.*

And when you start making payments, they can be any day of the month. Change days each month if you like. You'll only be paying interest on the money you owe. Because a PayAnyDay Vacation Loan is an extremely simple simple-interest loan.

And that's the way it should be when you're on vacation.



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The bank that says yes

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*Interest accrues from the date of the loan.

Every body system, every medical and surgical specialty, is included in and among the 33 chapters, and there is a good index, and an appendix containing such items as immunization recommendations, travel recommendations, laboratory test values, desensitization advice, controlled drug schedules, resuscitation, and so on.

I keep it on my desk top. You ought to have it there, too, no matter what your specialty!

HARRY L. ARNOLD, JR., M.D.



New Members



Joseph T. T. Hew, Jr., M.D.
888 South King Street
Honolulu, Hawaii 96813
GASTROENTEROLOGY



Gary McQueen, M.D.
1441 Kapiolani Boulevard
Honolulu, Hawaii 96814
GENERAL PRACTICE



Robert William Schulz, M.D.
888 South King Street
Honolulu, Hawaii 96813
PLASTIC SURGERY



Gareth C. Yokochi, M.D.
888 South King Street
Honolulu, Hawaii 96813
OBSTETRICS & GYNECOLOGY

Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

New Members—none again!

News of Members—Mark Sowers has given up after long tenure on Maui and is now associated with the Hilo Medical Group. **Ken Kern** has been approved for Active status and **Gwen Nishimura** of Kaiser is now a Resident-Affiliate. Secretary **Pat Dietrich** will be attending the State Officers Convention in Kansas City this month. The Junior League and the UH sponsored a 3-day seminar on The Family in Hawaii the end of March. **Don Farrell, Felix Lafferty, Fred Reppun, Dave Swanson** and **Nathan Wong** served as resource persons at the program's workshop on Family Medicine under the able direction of Sally McDermott.

Members Dropped—we have lost Student Members **Kathleen Ackerman, Patricia Chinn, Benedict Diniega, Kerrianne Garcia** and **Fred Royce. Vit U. Patel,** who is actually a psychiatrist, resigned. **Patrick Lowry,** who went into Public Health more than a year ago, has finally been dropped officially from membership in AAFP.

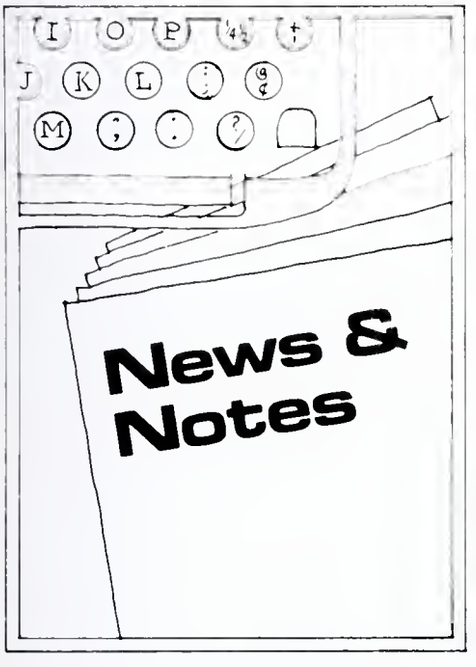
Dinner Meeting at Jasinskis'—a total of 60 were guests of **Cass** and **Doris Jasinski** at their Manoa home on April Fools' Day; of these, 33 were members, of which 13 were Student Members. Speaker Phil Jones gave his now famous discourse on Humanistic Medicine, and received considerable acclaim. Ed Hsia MD (pronounced chat, in French, he says) famed geneticist at Children's Hospital, held everyone's attention to his topic: How to Recognize Genetic Problems. Dr. Hsia was featured in the Star-Bulletin issue of 3/18/78.

Student Members—from now on will be free invited guests at our dinner meetings; this was approved at the March Council meeting. Their guests, however, will be charged the regular rate. Student Member **Howard Sakima,** UHSM '78, made a suggestion at that Council meeting that met with instant response: **Glenn Stahl** has already started to work on the suggestion that two lists be drawn up, one of willing practicing members and one of student members of HAFP. Glenn and Howard will then try to match the names so that each student member will have a physician member as his or her personal "Tutor" or "Sponsor" to serve in all sorts of situations most beneficial to the medical student learning what it is actually like to be a Family Physician. All of you call Glenn or Howard and SIGN UP!

A.A.F.P.—has signed up its 40,000th member!

P.P.S.A.—the Pan-Pacific Surgical Ass'n 14th Congress, as usual, comes out as being the ne plus ultra of all CME. Although "surgical" in scope, it brings to Hawaii a tremendous source of medical knowledge that is very fresh. Too bad it has never been Category "P"! We recognized **Pete Irwin, H.Q. Pang, Fred Reppun** and **Bill Walsh** as attending the 5-hour sessions each morning. If any other members of HAFP were there, please identify yourselves.

Advance Notice of CME—Core Content Review 1978-79 will be expanded to 8 months, offer 32 hours "P" and cost $55 to members. USC-UH 21st Annual PG Refresher Courses will include TAMC as sponsor, 12 to 23 Aug 78 and 14 through 18 Aug here in Honolulu. It will cost $325 and no exceptions.



HENRY N. YOKOYAMA, M.D.

Claude Caver's Witticism Part II

(Cont. from last issue)

(The FTC feels that competition will reduce doctor fees and so physicians should advertise their talents and wares. Claude has dreamed up some intriguing ads we can use.)

DO IT YOURSELF. We are the only authorized local dealers for the *LITTLE ACME "Do It Yourself" BRAIN SURGERY KIT*. Just look at the pictures and follow the instructions . . . PARAMOUNT CLINIC.

RENT A home kidney dialysis set. Complete line including hot and cold models for fast results. Special rates with and without immune globulin shots for hepatitis. Slight extra charge for our *Prepaid Funeral Services Plan* . . . EUREKA SERVICES, INC.

Trouble? "One call does it all." Call the *Hot Shot Family Clinic*. We treat everything from problem dandruff to ingrown toenails. Tired blood our specialty. Complete selection of prepackaged pills in decorator colors. Happy Hour Fridays 4-6 A.M. Located at Sand Island, next to the Outfall Pipe . . .

NEED MORE FIBER IN YOUR DIET? Dr. Organic Schmutzdecke has written a new book on the unlimited benefits of a high fiber diet. To guarantee that you get enough fiber when you have finished the book, you eat the book. INFINITE LIFE PUBLISHING CO.

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Life In These Parts

The "Death with Dignity" bill or "Living Wills" bill passed the House by a 38-8 vote, but the HMA and DOH urged the Senate Judiciary Committee to shelve the proposed bill because there is no medically operational or scientific definition of an "irremediable condition." (Later the bill quietly perished in the Senate Judiciary Committee.)

From George Daacon's column: "Split City: . . . And **Dr. Walter Yokoyama** and his wife Jean are preparing to split—With Walter insisting 'It's very amicable though—much like the Hemmeters.'"

"School Never Lets Out for Isle Doctors" The State will require certified evidence of 100 hours of CME credit every 2 years for relicensure beginning in 1980. **William Boysen,** former commanding general Tripler and new director of CME for the John Burn's School of Medicine says: "The concern is not just to get credit for so many hours, but to get them in a manner structured to individual needs and specialty. We don't want to get hours in basket weaving."

Oahu pediatrician **Wayne McKinny** who is crusading against the State's high rate of salmonellosis (8 to 10 times the national average) has run into opposition from neighbor islanders esp. a Bob Okawa, epidemiological specialist for the Maui division of DOH. It seems that the Dept. of Agriculture banned the sale of hog viscera in Oahu, but the neighbor islands had escaped the decree. Wayne wants hog viscera banned throughout the State, and Bob Okawa insists, "Banning pork intestines is like saying we should cut off our noses because they cause sneezing. No matter how much people scream and shout, Salmonella is still going to be here." So crusader Wayne continues to "scream and shout" that hog viscera have been banned in all the other 49 states and Hawaii should be no exception . . .

John Iaman from Majuro, Marshall Islands, is one of 5 physicians manning an 80 bed hospital. John was here for the 14th Pan Pacific Surgical Congress and explained their plight

wherein government red tape creates severe shortages of drugs and equipment in the Trust Territory. Before he came to the Congress, his hospital was virtually out of all antibiotics for 2 months despite repeated requisitions. The central supply office is controlled by the director of health of the Trust Territory in Saipan.

The DOH, for the 6th consecutive year, has asked the Legislature to lift its ban on the sale of condoms in vending machines. State epidemiologist **Ned Wiebenga** cited the 22% increase in GC over the past 2 years (from 2,923 reported cases in 1974 to 3,591 in 1976) and fears that the cases will jump to 4,200 in 1977. HMA president elect **George Goto** also testified: "We are convinced that easier access to prophylactics is necessary to stem the epidemic increase in venereal disease and unwanted pregnancies in this State." Some unrealistic law makers fear that vending machines will encourage sexual activity among school age kids . . .

At the regional meeting of the American College of Physicians in Honolulu, **James Grobe Jr.,** medical resident at Queens Medical Center reported that women between ages 30 to 60 have a 9:1 female-male incidence of carotid artery obstruction. James reports that 40% of the cases have concomitant renal artery obstruction and that another 30% have intracranial aneurysms. Suspect are hormones or birth control pills since the condition occurs in young women.

Another report on a joint study by **Dennis Wachi, Kevin Loh, Francis Oda, Noboru Oishi** and **Carol Cripps** shows that high dosage combination chemotherapy over a 10-day period every 4 weeks can extend the patient life of inoperable cancers of the neck, head and lungs by several months with minimal discomfort and good quality of life.

Honolulu infectious disease specialist, **Francis Pien,** reported that a recent study showed that Hawaii's high tuberculosis infected immigrant population does not show the resistance to anti-tuberculous drugs as is true in other foreign countries, esp. in Asia. Reports show as high as 50% resistance rate in Asia where anti-TB drugs are sold over the counter and even found in cough syrups. Hawaii's Tbc rate is 68 cases per 100,000 population (as compared to the national average of 14 per 100,000) with 80% of the active cases among the foreign born, esp. from Asia, and of these cases 60% occur within 2 years of arrival in Hawaii.

Tripler physician **James Lamiell** reported on an island family with 6 generations of Hippel-Lindau's (characterized by multiple internal tumors leading to paralysis, blindness and often death and which becomes apparent around age 30). There are only 50 to 75 cases reported in the world. The local family with 200 members is the largest family cluster ever reported. (Thus far 35 members are positive and another 10 to 15 positives may turn up within the next year.)

"Gynecologist **Richard 'Rick' Williams** purchased 110 tickets to the April 2 Heart Concert and 100 copies of Michelle Phillip's latest album to give as prizes at his upcoming sex seminar at the Ilikai called 'Close Encounters of the Fourth Kind'." (Daacon Mar. 23)

The Hospital Association of Hawaii (HAH) has a new Voluntary Cost Committee including physicians **Marion Hanlon, Elmer Johnson,** and **Rodney West.** The HAH committee is committed to "moderating the rate of increase in health care expenditure without reducing either the quality or accessibility of health care." It will attempt to cut back last year's 15% rate of health cost increase to about 2% per year.

Denis Mee-Lee, DOH chief of the Mental Health Division says that despite the rapid population growth in Hawaii, the number of patients in mental hospitals has continually dropped in a move toward "deinstitutionalization." Deinstitutionalization is made possible by the advent of effective drugs, new treatment methods, changing social attitudes and the movement towards community based mental health centers . . .

March of Dimes spokeswoman **Sharon Bintliff** denied reports that the March of Dimes is cutting back on genetic research and counseling programs because of pressures from anti-abortion forces which object esp. to amniocentesis . . .

Governor Ariyoshi announced that Wilcox Memorial Hospital on Kauai has been selected as an International Research & Reference Center for Blood Diseases and as the International Center for Health Education. The non-profit blood center scheduled to open later this year will employ 25 health professionals and will be budgeted the first year for $1.5 million. The center will use 4 existing laboratories and build a 2000 sq. ft. hemoglobin chemistry lab. The second project—the education center—will develop health education films for the lay and professionals. Considered are a conference center in a resort area with an amphitheater for 250, four smaller conference rooms and a training lab. The two projects are the brain child of Robert Schmidt, director of the hematology div., Nation Center for Disease Control (CDC) in Atlanta and also director of the World Health Organization program in blood diseases . . .

For the 4th year in a row, a bill to ease pot-use died in the House Judiciary Committee. Rep. Richard Garcia's bill would have included as petty misdemeanors only the following: Use of marijuana in public; possession of more than ounce in public; possession during the operation of an automobile or airplane; and possession or use by anyone under 18 years of age. The HMA's stand was that while it is opposed to legalization of pot, personal use of marijuana should not be subject to "disproportionate criminal penalties." Earlier the Senate Health Committee considered a bill allowing marijuana for medical reasons, but the committee did not even vote on the bill for lack of committee support . . .

Book Section

"Dr. Ron Pion, professor of OB & Gyn at UH Medical School, has resigned to devote more time to other projects—such as his 'The Last Sex Manual' which is set for a splashy April mainland promotion." (Daacon) (Ed: Now available at Honolulu Book Store at $10.95 hard cover and Ron promises a free autograph in his best scribble.)

"March issue of Playgirl features Kap Hospital's **Dr. Lawrence Reich** (clothed) who authored the best selling 'From Fat to Skinny.' Reich is just back from a mainland promo tour that started in N.Y.C. where a TV talk host, hearing of Reich's drastic weight loss (140 pounds), his quitting smoking and participation in the Honolulu Marathon, referred to him as 'The George Plimpton of Health'." (Daacon)

Kenneth Nakano, Straub neurologist, has authored a book entitled, "Neurology for Non-Neurologists." (**Mike Okihiro,** fellow Straub neurologist will keep us posted.)

"The Skin You Live In" by Norman Goldstein MD, FACP Dermatology. The truth about various skin problems. $10.95 hard cover, $5.95 soft cover. Available at Honolulu Book Store.

Miscellany

A psychiatrist and a proctologist opened a spanking new office in a small farming community . . . Their sign read, "Specialists in Psychiatry and Proctology." After a few weeks without any patients they realized that the townspeople did not know what psychiatry and proctology meant. So they put up a new sign, "Head Shrinker and Rear End Specialist." After a few more weeks without patients, they put up the sign, "Odds & Ends" . . . Now the townspeople flocked in for treatment . . . (As told by our golfing dentist friend Ken Ozaki)

Medical technology had advanced to the stage where brain transplants were feasible. A brain damaged person who had waited a long time was finally summoned by the transplant neurosurgeon. "You are indeed fortunate. This person just died in a car accident today." The patient asked, "Why am I so lucky?" "Well, the brain has hardly been used," replied the neurosurgeon . . . (As told by our golfing insurance executive friend Bob Kinoshita)

The rug between the twin beds was quite worn . . . Not so much by the light skip hop going over, but by the slow drag coming back . . . (Pure poetry by our engineer-lawyer friend Ralph Inouye)

Professional Moves

Homo Sapiens Medicus has finally simmered down and we note a settling calm in our medical community. During the month of March, in Honolulu, radiologist **Maurice Reeder**

associated with The Fronk Clinic; psychiatrist **Dennis B. Lind** relocated to Suite 907 Ala Moana Bldg. and internist **Marina Bumanglag** opened at 1270 Queen Emma Street.

On the Big Island, **Paul Matsumoto** (general and thoracic surgeon) opened at the Medical Center, 670 Ponahawai St., Hilo. Kohala will have **Zander Van Rilland** working with **Michael Padwick** at the Kohala dispensary.

On the Garden Island, **Robert Myles Riner** joined the Wilcox Hospital Emergency Staff while internist **Neal Sutherland** joined the Kauai Medical Group Inc.

On Maui, FP **Mildred Ella Ward** and FP **Lawrence Ralph Raithus** joined **J. Mark Sowers, E. Morris Hayes** and Sowers & Strother MD Inc. at 1827 Wells Street, Wailuku.

In the last issue we had announced that cardiologist **Richard Reeve** had opened at 848 So. Beretania, Suite 315 in August, but we were corrected by Dick who had moved into Suite 539, 1481 So. King St. in September. (Ed. It brightened our day to learn that someone actually reads through this column, even though we had to answer our Pageboy on our precious afternoon off . . .)

Miscellany

It was Johnny's first day at Uncle Bill's drug store as part time helper. Uncle Bill asked Johnny to mind the store while he went to lunch. A man came in and he was in a hurry to get something for his bad cough . . . His bus was due any minute . . . Johnny looked around for some familiar remedy and spied the bottle of Ex-Lax. With new found assurance, he told the man "Here, take one or two as needed." The man gulped down a half dozen pills and went back to the bus stop . . . Uncle Bill returned shortly and asked how things were and Johnny explained what had happened. "You don't give Ex-Lax to stop a cough," snorted Uncle Bill. Johnny looked toward the man waiting for his bus in obvious agony. "See that man at the bus stop? He don't dare cough."

(As told by **Ed Kagihara**)

Sportsmen

Golfers:

The HMA Golf Committee (**Henry Yokoyama, Bill Dang, Tom Kobara, Don Lau** (Dorsey man) and **Jim Navin**) has reserved Mid Pac CC for Wednesday October 4. Times available: 7 am to 9:30 am; 1:01 pm to 2:11 pm. Prime time reservations also to be made by Mid Pac CC members.

Joggers:

Back in December, **George "Bill" Starbuck** was training for the Marathon and got a ticket for "jay jogging" at the corner of Kilauea and Waialae when he crossed on a red light. George got a suspended 6 months sentence . . .

Walter Young's Repertoire

A man suspected his wife of cheating so one morning, instead of going to work, he returned to his 6th floor apartment two hours later. He flung open the door and burst into the living room which was empty. He dashed into the bedroom exclaiming, "Gottcha!" but alas the bedroom was also vacant. He found his wife in the bathroom still in her nighties and shouted, "Where is he?" "What are you talking about?" rebutted his wife . . . He ran to the open kitchen window and saw a man running from the building. Enraged, he picked up the refrigerator and threw it down at the culprit . . .

Scene at the Pearly Gates . . . Three men are asking St. Peter for permission to enter . . . The first man: "St. Peter, you may find this story hard to believe, but I was late for work and was running for the bus stop when a refrigerator fell out of the sky and crushed me." St. Peter believed him and allowed him to enter. The second man related, "In a fit of rage, I threw a refrigerator out of my kitchen window and suffered a massive heart attack." St. Peter admonished him, "You should learn to control your temper, but you may enter." St. Peter turned to the last man, "Why are you here?" "Well Sir, I was in that refrigerator."

Hors de Combat

A year long study by the Council on Wage and Price Stability reports that since 1950 physician fees have climbed 80% faster than consumer prices in general and that no relief is in sight. The primary cause of rapidly rising fees since the mid 60's has been the extraordinary growth in private and public health insurance coverage. Currently 170 million or 80% of the population has private health insurance covering doctor's services. Other major points of the report are: The median income of doctors was $63,000 in 1976; pathologists and radiologists have the highest earning among specialty groups, about $100,000 annually; OB GYN: $76,000, Surgery: $70,000, Internist: $60,000, pediatrics: $51,000 and GP: $47,000 . . . There is one doctor for every 565 people compared to one for every 719 in 1960 and by 1980, the ratio will be one for every 450 . . . Specialists comprise 85% of all doctors as compared to 40% in 1970 . . . Malpractice insurance rose 84% in 1975, 42% in 1976, and has leveled off . . . "Rate of return on investment in medical training are far in excess" of other fields . . . The report states that the nation's nearly 400,000 doctors have virtually no outside restraints on fees they charge and some may even set "target levels" for their annual incomes. The AMA is disappointed that the report failed to offer any positive recommendations on controlling costs . . .

In the aftermath of the ruckus at MMH (Maui Memorial Hospital), DOH's deputy director Henry Thompson recommends 46 new positions or double the earlier estimate. DOH is also backing legislation to authorize an additional $250,000 to be spent on upgrading the ambulance and emergency services. The DB&F (Dept. of Budget and Finance) chief of budget planning, a Dennis Goda (a Maui boy) is contesting these promises . . . **William Kepler,** MMH chief of staff was pessimistic: "That's terrific news if it's true" and expressed doubt that the State can make good its projections . . .

A John Moreno makes a point in a letter to the editor entitled: "Doctors and Medicaid." "When federal funds are involved, accountability is most important and no doctor need be ashamed if he charges correctly and honestly. And if that doctor feels ashamed, he should recall that Truman once said, 'If you can't stand the heat in the kitchen, get out.' . . . Publishing the entire list of doctors, even to the minimum amount a doctor may receive, is correct and justified . . . The honest ones will stand up against any criticism."

Anesthesiologist **Mitsuo Hattori** who lives in Haiku Plantation in Kaneohe had a real fright when his 7-year-old daughter and another child ate the pods of the kukui haole, or *Jatropha curea*, or the physic plant, which closely resembles the kukui nut and is used for poisoning rats and fish. Luckily Mitsuo was around when his daughter Tamiko complained of a burning throat, broke out in hives, started massive vomiting, then went into cardiovascular shock. "If I wasn't around, she might be dead. I'm not exaggerating," said Mitsuo, who feels that everyone should know about what kukui haole seed can do . . .

Two bills which would have allowed pharmacists to dispense generic drugs when not specifically forbidden by a doctor were shelved by Anson Chong's Senate Health Committee for lack of support . . .

Our "Angels"

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Hawaii Medical Journal

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Before prescribing, please consult complete product information, a summary of which follows:
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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,00 Persons When States Adopt Cooperating Laws—He C the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14, The Social Security Bill, pro a broad program of unemplo insurance and old age pe and counted upon to benefi 20,000,000 persons, became l day when it was signed by dent Roosevelt in the prese those chiefly responsible fo ting it through Congress.

Mr. Roosevelt cal[illegible] "the cornerstone [illegible] which is being [illegible] me[illegible] rin[illegible]

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today 94 to 0 and sen[illegible]

TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

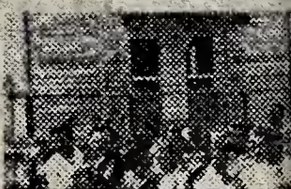
The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

IGNE the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

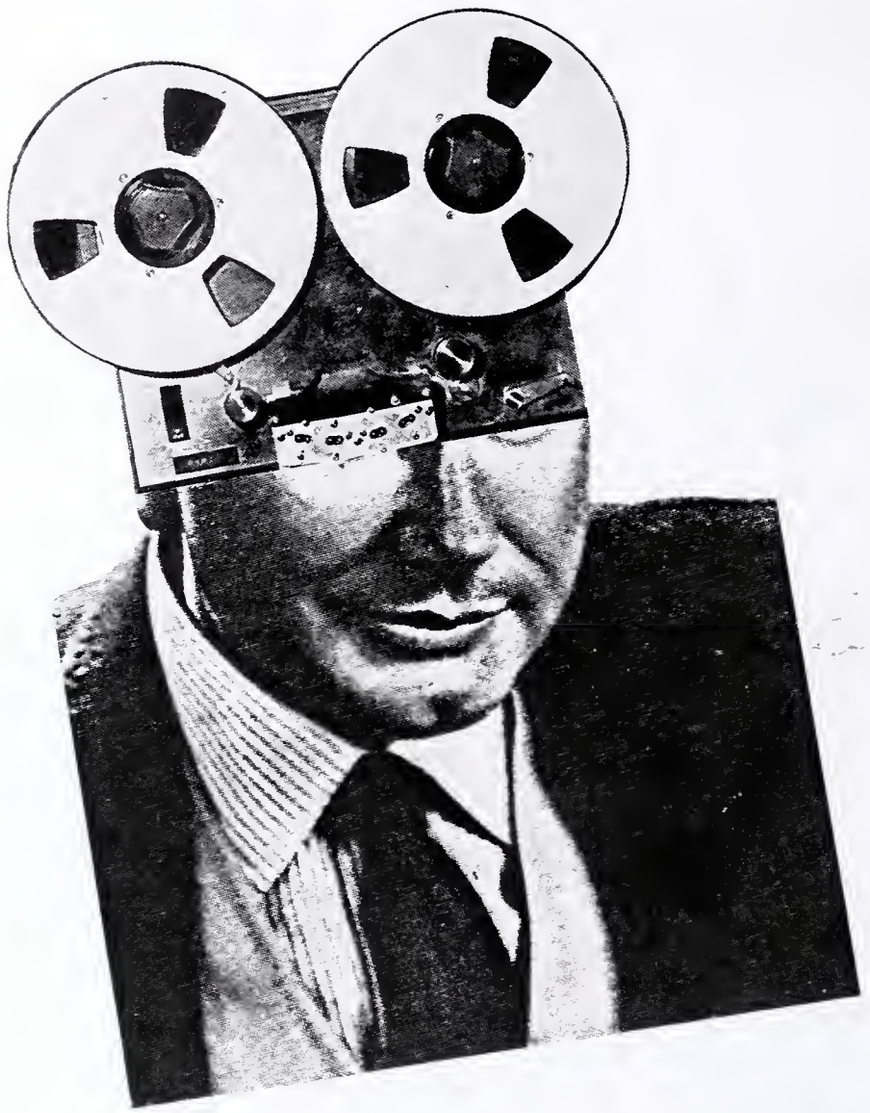
These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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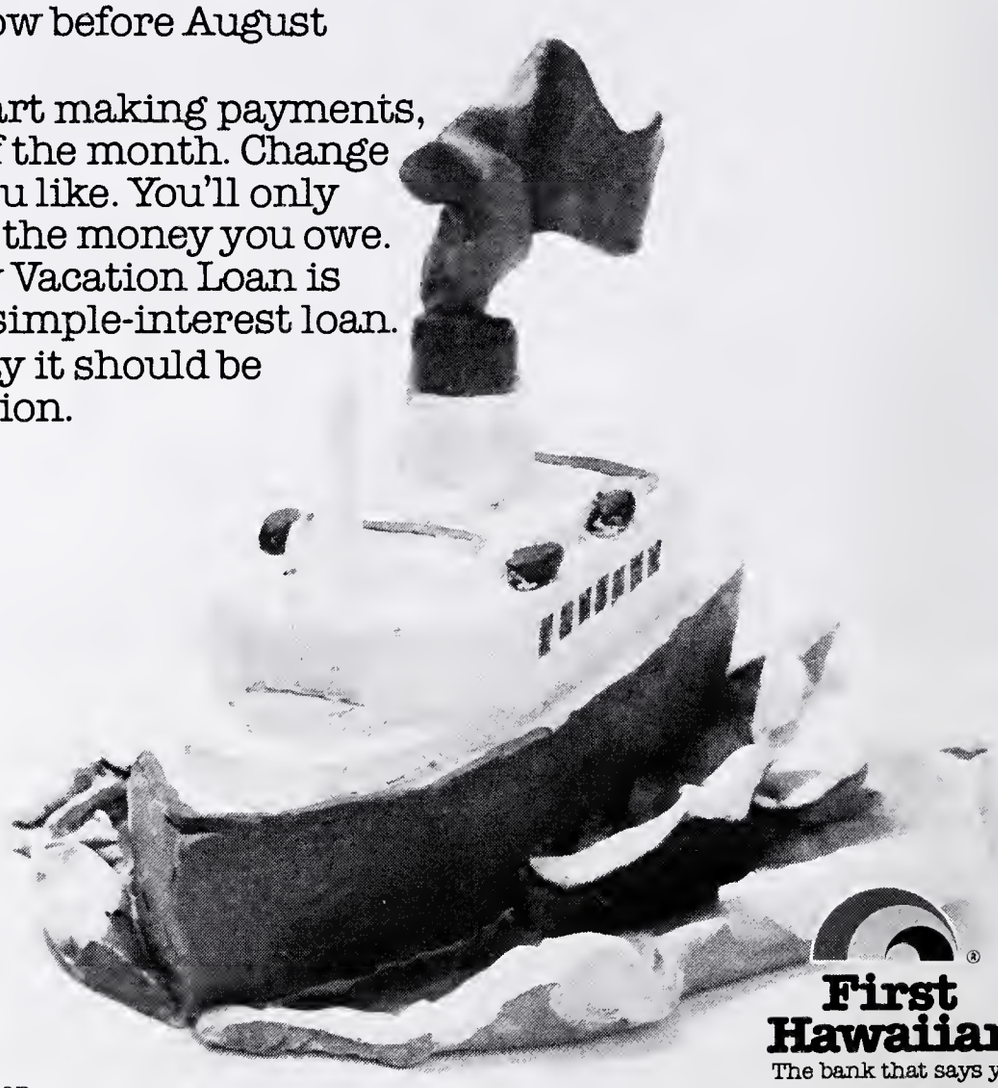
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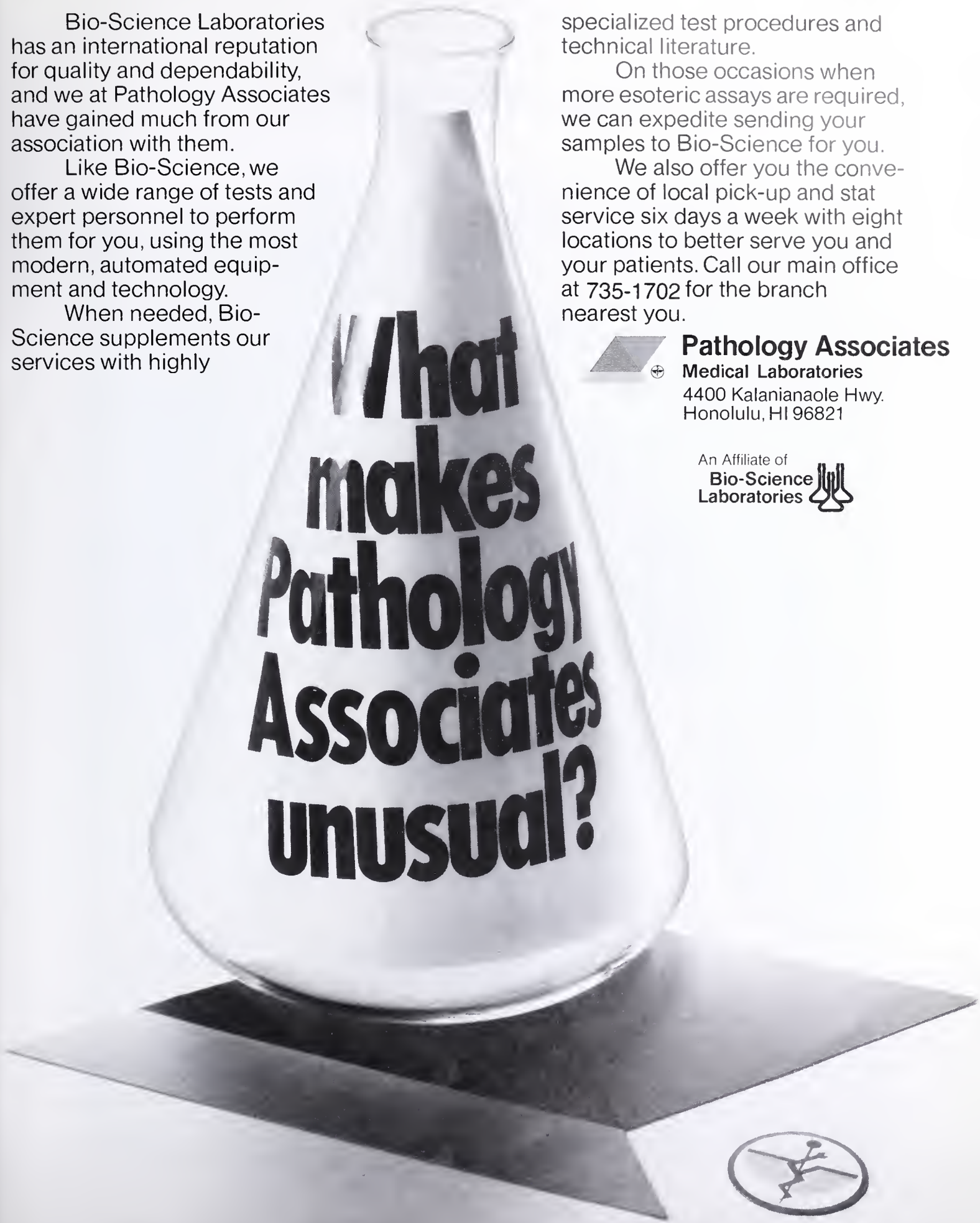
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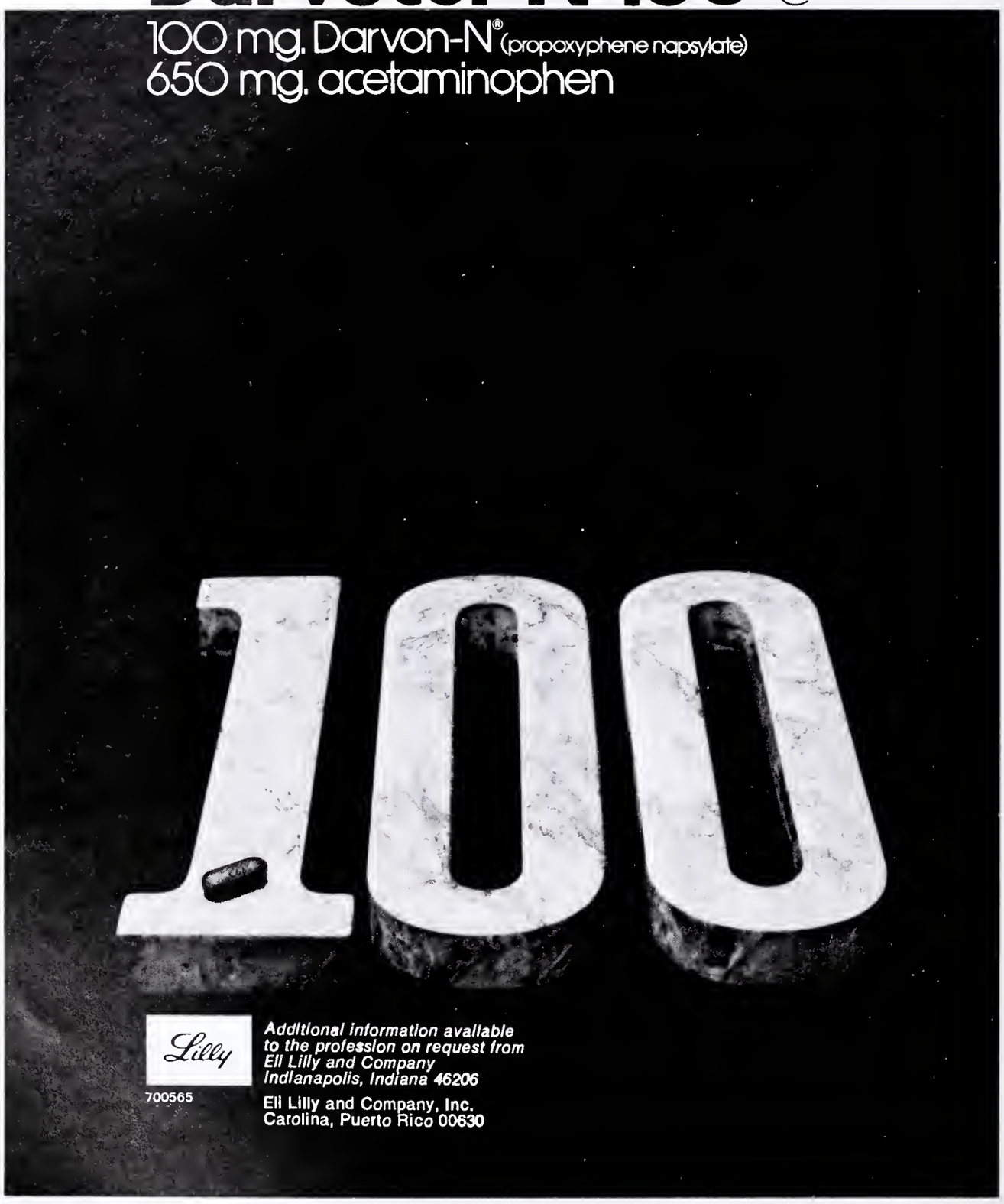


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Psychological Preparation for Surgery: The Usefulness of a Preoperative Psychotherapeutic Interview

JON STRELTZER, M.D. *and* HOYLE LEIGH, M.D.

• *The medical literature reveals that preoperative psychologic states are important in postoperative course, and preoperative psychiatric interviews may have a beneficial effect, especially in cardiac surgery patients. We studied 18 consecutive patients admitted to a general surgical floor, anticipating peripheral vascular surgery pre- and postoperatively. Half of the patients were offered a psychotherapeutic interview preoperatively (interview group) to find out if they would be ready to utilize those interviews in a therapeutic manner, and whether they would have beneficial effects postoperatively. Our results show that all the patients who were offered interviews utilized them primarily to ventilate their anxieties about situations which included but were not confined to the surgical procedure. The "interview" group tended to have a shorter postoperative course than the control group.*

Since Janis' classic study identifying elective surgery as a model of a stressful event,[1] there has been interest in identifying and influencing preoperative factors that effect postoperative course. Janis observed that high preoperative anxiety correlated with high postoperative anxiety, and that excessive preoperative denial predisposed to postoperative depression. He postulated that a patient needs to go through the "work of worrying" for optimal preoperative psychological conditions. Abram and Gill[2] used preoperative psychiatric interviews to successfully predict the postoperative psychological state. They found that immediate preoperative factors, such as expectations of surgery, correlated more with postoperative course than historical factors such as previous psychiatric treatment. Williams and Jones,[3] in a study of preoperative medications, concluded that preoperative anxiety affected postoperative physiological status. Kimball,[4] studying open-heart surgery patients, found that preoperative psychological factors were related to postoperative length of stay, complications, and deaths.

Others have attempted to influence postoperative course by means of preoperative interventions. Egbert[5] was able to reduce postoperative analgesic requirements by preoperative encouragement and instruction. Andrews,[6] however, found that tape-recorded instructions prior to surgery had no effects on recovery from surgery.

Lazarus and Hagens,[7] and Layne and Yudofsky,[8] associated a reduction in the high incidence of postoperative psychosis in open-heart surgery patients with their preoperative psychiatric interviews. Layne and Yudofsky did not have a control group, however, but rather compared the incidence of postoperative psychosis in their series to higher incidences reported by others. Lazarus and Hagens did have a control group, but they manipulated the postoperative environment, in addition to using a preoperative psychotherapeutic interview, and thus it is not clear what effects were due to the psychiatric interview alone.

The weight of accumulated evidence indicates that the preoperative psychological state of the patient is an important factor in determining the postoperative course. In fact, routine psychotherapeutic intervention has been recommended for cardiac surgery during the preoperative period by several authors.[6,7,8,9] It is possible, however, that patients anticipating cardiac surgery have a higher anxiety level, resulting in their increased readiness to utilize a psychiatric interview. Would general surgical patients undergoing a relatively less serious procedure than

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open-heart surgery be able to utilize and possibly benefit from a single unstructured psychiatric interview if the opportunity were offered? Would they be willing to use such an interview at all?

Method

A total of 18 consecutive patients admitted to general surgical floors for elective peripheral vascular surgery, during the designated 5-month period, were studied. These patients were typically admitted a few days prior to surgery, which allowed the interviewer to see them preoperatively. All patients were operated on by one of two surgeons. When the decision to operate was written in the chart, patients were placed alternately in the "interview" or the "no interview" (control) group.

THE INTERVIEW

All patients in the "interview" group were invited to talk about their feelings with the interviewer for approximately an hour. The interviewer, a senior psychiatric resident (J.S.), introduced himself to the patients as a member of the hospital staff doing research related to the people's emotions and feelings about being in a hospital awaiting surgery. All the patients readily agreed to the interview. No other contact was made except with one patient who specifically asked the interviewer to return postoperatively. The surgeons and nurses were not informed about the nature of the study or which patients were to be interviewed. The presence of the interviewer on the floor was taken for granted as he was regularly present on the surgical service as a liaison psychiatrist.

The interview was unstructured but the following areas were generally covered: 1. patient's understanding and expectations of surgery; 2. fear and anxieties relating to hospitalization and surgery; and 3. current life situation. Questions were encouraged. They were answered by the interviewer when possible, or the patient was advised to ask his surgeon. Ventilation and expression of anxiety were encouraged, with the message, "It's OK to be anxious." Essentially the interview was conducted in the manner described by Lazarus and Hagens,[6] and followed the therapeutic principles described by Hackett and Weisman.[10,11]

COLLECTION AND ANALYSIS OF DATA

Immediately after each interview, a detailed summary was recorded which included major themes, the patient's response to the interviewer, and the interviewer's opinion of the effectiveness of the interview. Later, charts were reviewed and demographic data, medical histories, and data pertaining to hospital course were tabulated. Finally, comparison was made between the "interview" and control groups.

Results

THE INTERVIEW

The results of the interviews are presented in Table 1. All patients readily agreed to the interview, and every patient used the occasion to express anxiety about loneliness, helplessness, and major life changes. No patient expressed a negative opinion about the interview, and 8 (89%) expressed gratitude for the opportunity to talk to the interviewer. The interviewer judged that he had been helpful to 7 (78%) patients, and possibly helpful to one more.

TABLE I.—*Results of Psychiatric Interview of Nine Surgical Patients*

		No. of Patients
Ventilation Occurred		9
Themes: Helplessness	5	
Loneliness	3	
Major Life Change (Retirement)	1	
Patient Volunteered Gratitude For Interview		8
Patient Expressed Negative Feeling About Interview		0
Psychiatrist Felt Patient Helped By Interview		7

The following vignettes are presented to convey the flavor of the interviews:

Case 1: A 62-year-old widow initially responded to the interview by saying, "You're interested in the psychological aspect. Okay, I've nothing else to do." She proceeded to describe her medical history, and pointed out that because of her hip fusion and the fact that she lived alone, she would not go directly home from the hospital after surgery, but instead to a special convalescent unit. She said that she understood her operation and wasn't afraid to ask questions. Then, in the middle of the interview she began to weep: "You want to know what's really bothering me? I have to go through it all alone." She described how her husband had died two years before, and the difficulties in living alone. At the end of the interview she said it helped to have a good cry, and she asked the interviewer to return after the operation and see her again. This was done.

Case 2: A 76-year-old unkempt man was the only patient who seemed to have a slight organic brain syndrome. He initially stated that he felt fine and was quite comfortable. He was in the hospital "because the doctor wants me here." When the interviewer responded with great interest to the patient's description of his career as a boxer, the patient began to verbalize more freely. He compared with dismay his present semi-invalid state to his younger active self. He complained of difficulty sleeping in the hospital. He lamented, "I wish I weren't here. My time may be up." The interviewer joined the patient in

a discussion of hardships of hospitalization. Following this, more future-oriented topics emerged. Although encouraged to ask for pain medications if needed postoperatively, he insisted he would ask for nothing and take only what was given to him. (Indeed, he received no analgesics at any time in his entire hospital course.) The patient thanked the interviewer warmly for coming.

Case 3: A 59-year-old divorced man identified the interviewer immediately as a psychiatrist and began to talk about his sexual history and recent impotence with his girlfriend. His greatest fear was of being helpless after the operation, and he reported being delirious following an operation for a bleeding ulcer 6 years previously. His fears about the possible need for a urinary catheter were discussed at length. He was encouraged to find out from his surgeon if he would need one. He described himself proudly as an aggressive man. The interviewer supported his "aggressiveness" and sense of masculinity by saying that it was important to ask questions and make one's needs known even in the hospital. The patient was very appreciative of the opportunity to talk with the interviewer. His discharge summary included the following: "His postoperative course considering the severity of his disease and the seriousness of the surgery has gone remarkably well."

POSTOPERATIVE COURSE

The actual operation was different from the vascular surgery anticipated at time of selection for the study for 4 patients, and, thus, they were eliminated from the study of postoperative course.

There were no significant differences between "interview" and control groups in demographic data, medical diagnoses, number of prior operations, anesthesia time, anesthetic used, and number of units of blood transfused at operation (see Table 2). Preoperative EKG, if anything, favored the control group in which 4 of 8 were read as normal compared to 0 of 6 in the "interview" group. Anesthesiologists' preoperative ratings of physical status were "2" for 3 "no interview" (control) patients, and "3" for the other 5 controls and all the 6 of the "interviewed" pa-

TABLE 2.—*Data Comparing the Interviewed and non-Interviewed Patients*

						POSTOPERATIVE					
	SUBJECT[A]	SEX	OPERATION	AGE	ANESTHETIST RATING	DURATION OF ANESTHESIA (HRS:MINS)	DAYS IN HOSPITAL	DAYS TO 1ST AMBULATION	CONSULTS	COMPLICATIONS	TOTAL[G] PARENTERAL PAIN MEDS (MGS OF MORPHINE)
Interview	I1	F	abd aortic aneurysm resection	62	3	5:40	11[B]	6	0	0	60
	I2	M	femoral-popliteal bypass	76	3	5:30	9	4	0	0	0
	I3	M	aortic bifurc graft	59	3	6:30	15	6	0	0	105
	I4	F	femoral popliteal bypass	55	3	4:20	10	1	0	0	27.5
	I5	M	carotid endarterectomy	68	3	3:00	13	5	0	1[D]	5
	I6	F	femoral-popliteal bypass	72	3	4:20	12	3	0	0	45
	Mean			65.3	3	4:53	11.7	4.2	0	0.2	40.4
No-Interview (Control)	C1	M	femoral-femoral bypass	73	3	4:40	15[C]	9	0	0	0
	C2	F	aortic bifurc graft	55	2	4:55	13	7	0	0	66.7
	C3	M	ilio-popliteal bypass	70	3	5:20	18	8	1	1[E]	30
	C4	M	ilio-femoral endarterectomy & sympathectomy	77	3	2:30	43	2	0	1[F]	27.5
	C5	M	femoral-popliteal bypass	61	3	4:25	15	2	0	0	25
	C6	M	abd aortic aneurysm resection	59	2	5:05	24	13	1	5[F]	117
	C7	M	abd aortic aneurysm resection	65	3	5:15	11	6	0	0	65
	C8	F	femoral-popliteal bypass & ilio-femoral endarterectomy	66	2	6:25	10	4	0	0	25
	Mean			65.8	2.6	4:49	18.6	6.4	0.3	0.9	44.5

A 11 - 13 and C1 - C5 had surgeon A. 14 - 16 and C6 - C8 had surgeon B.
B Transferred to convalescent unit for 19 more days.
C Transferred to another hospital by family request for 34 more days.
D CVA.
E Wound infection.
F Cardiac arrest; aspiration pneumonia; CHF; acute tubular necrosis; wound dehiscence.
G 100 mg meperidine=10 mg morphine (16).

tients. (The American Society of Anesthesiologists grading system[12] defines a physical status of "2" as "mild systemic disease," and "3" as "severe systemic disease that limits activity but is not incapacitating." Thus, these ratings also favored the control group.)

A trend toward a shorter postoperative hospital course in the "interview" group was found ($t=1.54$, $df=12$, $p<.10$, one-tailed). Although not statistically significant, on the average more postoperative consultations, complications, and days to first ambulation occurred in the "no interview" (control) group than the "interview" group. The two groups were very similar in the mean and range of pain medications received.

Discussion

A pertinent finding in this study is that all the interviewed patients used the interview in a psychotherapeutic manner. Since these patients were chosen at random and only two had had prior experience with psychotherapy, it is noteworthy that each had areas of concern which were readily discussed, with ventilation of anxiety. Most patients reported feeling more comfortable as a result of the interview. Perhaps the "stress" of anticipation of surgery, even if the procedure were not as threatening as open heart surgery, worked as a catalyst in their readiness to discuss other life situations causing anxiety. Just as psychotherapeutically-oriented interviews can be helpful in such nonpathological conditions as grief reactions,[13] so may the common but individual specific fears and anxieties in preoperative patients be helped by the type of interview reported in this study.

The small sample size may have contributed to the failure of the measures of postoperative course to reach statistical significance. The trend in the predicted direction for length of postoperative stay is, if anything, more impressive, since the preoperative data tended to favor the control group.

The amount of narcotic analgesics used was remarkably low in both groups, 2 patients receiving none at all! The experience of the authors is that narcotics tend to be underused in the hospital in question, in much the same manner as that reported by Marks and Sachar.[14] Indeed, the interviewer encouraged the patients to ask for medication when they felt pain.

Methodological problems arise in undertaking a larger study of this type, in contrast to Janis' 1958 study. Nowadays, for most types of surgery, a patient is admitted to the hospital no sooner than the night before, leaving little time to schedule an interview. Nevertheless, larger studies are needed to cross-validate our results showing that preoperative patients use unstructured psychiatric interviews therapeutically, and to test the possibility that such interviews might favorably influence a postoperative course. Surman *et al*[15] reported an attempt to benefit cardiac surgery patients through the use of preoperative psychiatric interviews failed to achieve significant results. The interview utilized in their study was qualitatively different from ours. Theirs included instruction and hypnosis. An unstructured interview like ours which encourages ventilation around such themes as helplessness and loneliness, may be of more benefit.

If even slight decreases in morbidity, mortality, and length of hospital stay are found, this would more than pay for the cost of a routine preoperative psychotherapeutic interview for all elective surgery. In addition, the evaluative aspects of a psychiatric interview could identify potential management problems before they occur. Future studies should also include the use of non-psychiatrist interviewers, perhaps nurse clinical specialists and surgical residents who would be more readily available on a large scale to work on surgical services.

The most practical and valuable approach could well be training surgeons to perform such interviews themselves. A surgical residency should ideally include training in the psychiatric aspects of surgery. We suggest this should also include training in performing preoperative psychotherapeutic interviews. Just as every effort is made to optimize a patient's physical state prior to surgery, so should every effort be made to optimize the psychological state.

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Effect of Oral Bromelain on Blood Pressure and Heart Rate of Hypertensive Patients

ANDREW E. GUTFREUND, M.D., STEPHEN J. TAUSSIG, Ph.D., *and* ALFRED D. MORRIS, M.D., *Honolulu*

• *The effect of oral bromelain upon blood pressure and heart rate of 19 patients has been studied. Dosage of bromelain up to twice the maximum recommended had no effect upon blood pressure or heart rate. When the dosage was increased up to 8 times the maximum recommended, the heart rate increased proportionately with the amount administered. Blood pressure however, remained unchanged. These findings suggest that oral bromelain is safe and add further evidence to the hypothesis that the effect of bromelain is related to its action on endogenous prostaglandins.*

Bromelain is a proteolytic enzyme system extracted from the pineapple plant. Its main component is a sulfhydril protease, with traces of acid phosphatase, peroxydase, protease inhibitors and several low molecular weight compounds. It has been suggested for several applications: as an anti-inflammatory agent, as a digestant, for enhancing the absorption of antibiotics, and as a supporting drug in cancer therapy,[1] among other purposes.[2]

Bromelain has been described as effective in cardiovascular diseases as an inhibitor of blood platelet aggregation,[3,4] minimizing the risk of arterial thrombosis and embolism. It has been suggested that the therapeutic effect of bromelain might be due to its stimulatory or inhibitory action upon the biosynthesis of endogenous prostaglandins.[2,5]

Prostaglandin E_2 (PGE_2)-type compounds, like PGF_2, thromboxane A_2 (TXA_2) and endoperoxide intermediates (PGG_2, PGH_2) have inflammatory and vasoconstrictor properties. Conversely, prostaglandin E_1 (PGE_1)-type compounds, like prostaglandin A_1 (PGA_1) and prostacyclin (PGI_2), are vasodilators and anti-inflammatory.

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Dr. Morris is a cardiologist with the Honolulu Medical Group. Inquiries should be addressed to Dr. Taussig.

Bromelain is an inhibitor of PGE_2,[6] but its effect on PGE_1-type compounds is uncertain. It either stimulates or does not affect them. Thus, bromelain will modify the ratio between the two prostaglandin types with opposite effects. If this hypothesis is correct, it would be expected that, because the equilibrium is shifted in favor of PGE_1, bromelain would elicit effects characteristic for PGE_1-compounds.

The purposes of the study were: 1. To determine to what extent increasing doses of bromelain affect the blood pressure and heart rate of humans. 2. To find out what effects high doses of bromelain have on hypertensive patients. 3. To detect side effects caused by high doses. 4. To determine if administration of bromelain produces effects characteristic for PGE_1-type compounds.

Materials and Methods

The bromelain used in the study was in the form of Anavit-F3, supplied by C.C.I., Inc. of Honolulu, Hawaii. Each capsule contains 230 mg of bromelain of 1200 GDU (gelatin digestion units) per gram as the active ingredient, with 15 mg of ascorbic acid. The bromelain used in Anavit-F3 was manufactured by Castle & Cooke Foods in Honolulu. It is important to note that, although all commercially available bromelains are standardized to 1200 GDU per gram proteolytic activity, the product made in Hawaii has a significantly higher physiological action, tested on blood platelets, than most other bromelains.

The study was carried out on 19 patients, 17 being hypertensive, including 7 women and 12 men between 33 and 73 years of age (Table 1). The average age (excluding patients 1 and 2, who dropped out of the test) was 61½ years; the mean blood pressure was 189/98. Blood pressure and heart rate of each patient were measured for 3

consecutive days before the test, after relaxing for 10 to 15 minutes. The mean value of 3 readings was used as baseline.

The bromelain was administered to the patients for strictly experimental purposes. Although most of the subjects belonged to the geriatric group and had various complaints, the only common denominator was hypertension. The bromelain was administered always in one dose. Patients were informed of the purpose of the test and possible risks involved, and participated voluntarily in the study. Each patient served as his or her own control, based on measurements made before the test.

The study was an open trial conducted in ambulatory patients, and therefore was subject to methodologic limitations. The test was designed for administration of a maximum of 8 capsules per patient. It was started with 1 or 2 capsules; if the patient did not develop any side effects, the next higher dosage was tested. Thus, dosage was increased gradually. As soon as undesirable symptoms appeared, the test was stopped. In such cases, potent prostaglandin inhibitors (e.g., aspirin, indomethacin) were promptly administered.

Increasing amounts of bromelain were administered orally, in a single dose. Each patient took only one dose in one day and at least 24 hours elapsed (generally more), before the next higher dose was given. Blood pressure and heart rate were measured before, and ½ hour, 2 hours and 24 hours after, bromelain administration, always after a 10-15 min period of relaxation. All patients were ambulatory and pursued their normal daily activities during the test. When a patient developed noticeable (mostly subjective) side effects, the test was repeated, but the dose was not increased. This happened with only 3 patients. Otherwise, the dose was gradually increased, up to 8 capsules. The maximum recommended dose for bromelain is 230 mg (1 caps Anavit F-3) at a time, for any therapeutic application. Thus, the highest dose tested exceeded by up to 8 times the normally recommended amount.

FIG. 1. *Effect of oral bromelain on the blood pressure of hypertensive patients (average of 13 subjects). The numbers on the curves indicate the number of capsules taken in one dose. The values are expressed in % of the baseline value. The curves start at ½ hr, because of the logarithmic scale of the abscissa.*

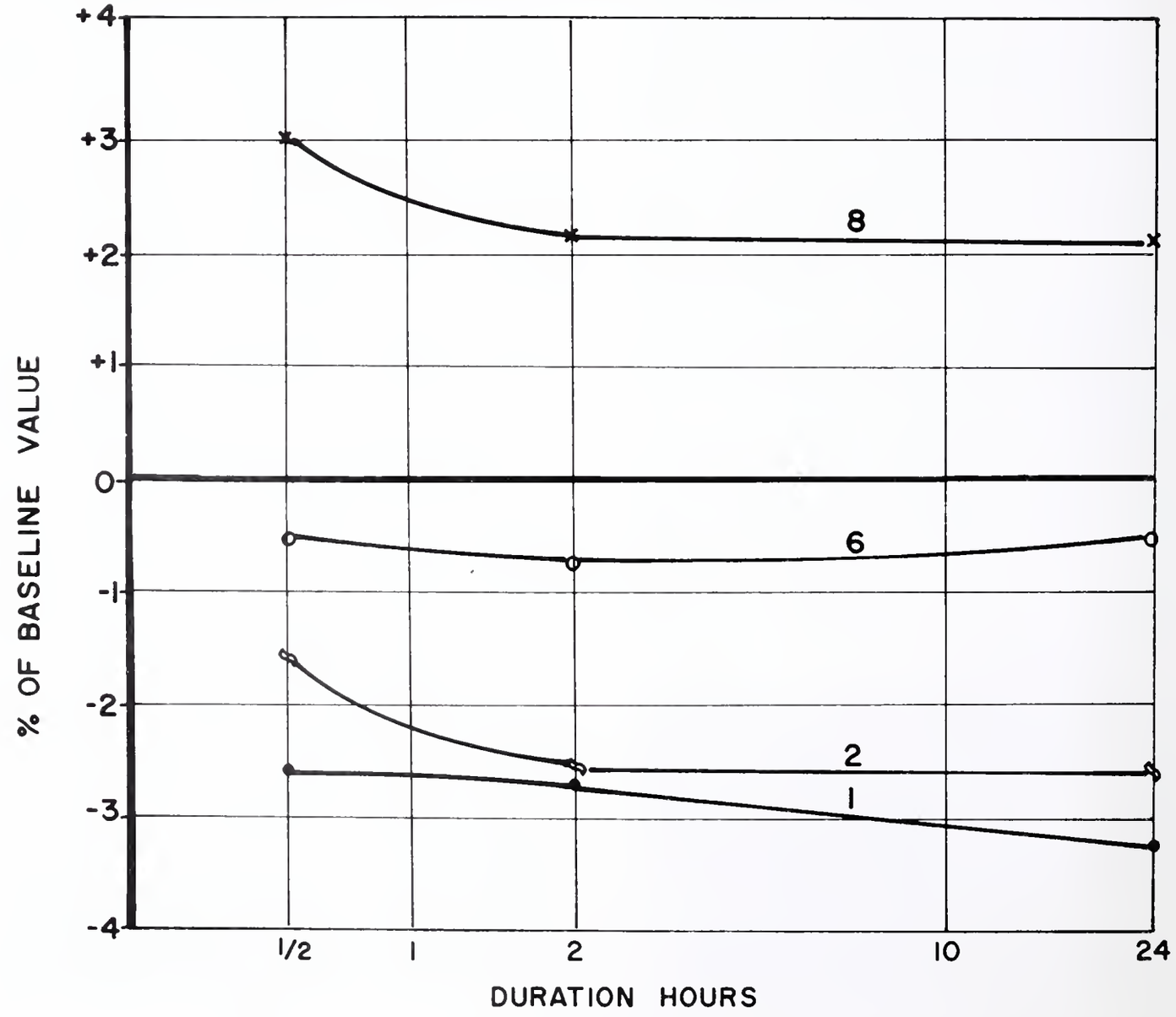


Fig. 2. *Effect of oral bromelain on the heart rate of hypertensive patients. The numbers on the curves indicate the number of capsules taken in one dose.*

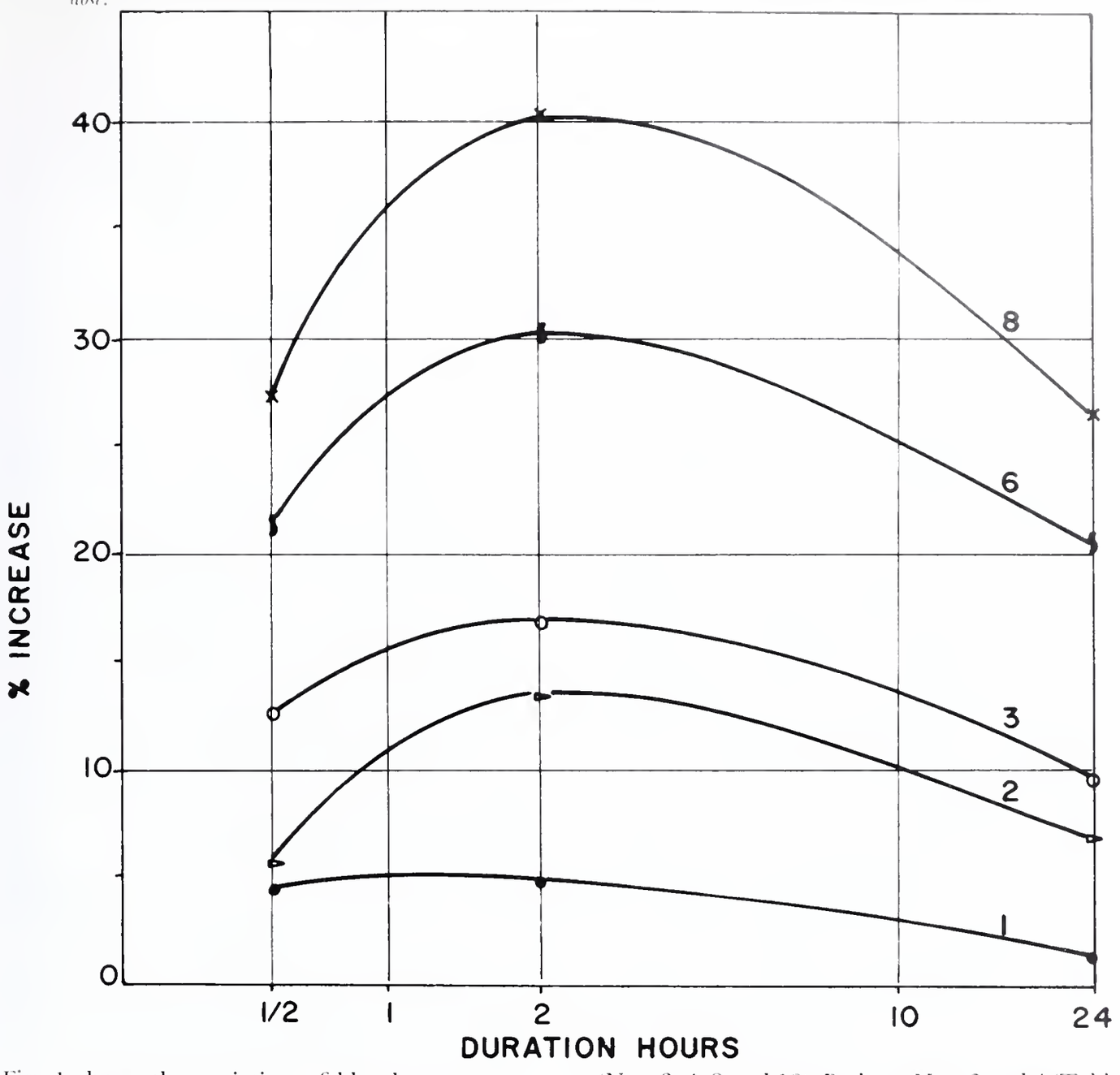


Fig. 1 shows the variation of blood pressure and Fig. 2 the variation of heart rate for different dosages as a function of elapsed time. The values are averages for 13 patients. Excluded were patients Nos. 3, 4, 8 and 19 (described below) and Nos. 1 and 2 who dropped out from the test for nonmedical reasons.

Up to 2 capsules, heart rate and the blood pressure remained practically unchanged. With increasing dosages, the heart rate increased proportionately; in some cases at the maximum dosage increased up to 80% above the baseline. The maximum effect was reached approximately 2 hours after bromelain administration. A residual effect was noticeable even after 24 hours. The blood pressure of the patients was not affected at any dose level tested (Fig. 1). The differences between blood pressure readings are insignificant and are within the limits of error of the measurement.

The trend for changes in blood pressure and heart rates were similar for all but 4 patients (Nos. 3, 4, 8 and 19). Patients Nos. 3 and 4 (Table 1.), were overweight women (176 and 230 lbs. respectively). Both developed, after 3 capsules, subjective discomfort and palpitation. After administration of indomethacin, the symptoms disappeared within 2 hours. During that time the blood pressure did not change, nor did the heart rate increase above the average. When the test was repeated on these patients, each time they developed the same subjective symptoms.

Patient No. 8, a woman (172 lbs), developed diuresis after 6 capsules, and felt nauseated and weak. Her blood pressure remained unchanged and her heart rate increased by 46%. After she was given aspirin, her symptoms disappeared and her heart rate returned to normal.

Patient No. 19, a man, age 71, developed no side effects after doses up to 8 capsules. His blood pressure decreased only slightly, but unlike all others, his heart rate did not increase. Therefore, we did not include this patient in the graphs.

TABLE 1.—*List of patients who took part in the study.*

NO.	NAME	SEX	AGE	WT. KG.	BASELINE VALUES BLOOD PRES.	PULSE	REMARKS.
1.	WW	M	51	84	115/80	82	Dropped out
2.	SM	F	33	61	135/80	76	Dropped out
3.	SB	F	57	76	160/90	82	Palpit. aft. 3 caps.
4.	MD	F	58	104	145/100	85	Palpit. aft. 3 caps.
5.	OM	M	58	104	140/95	68	
6.	PT	M	58	91	150/85	76	Dysphag. improved
7.	BH	M	73	70	180/90	84	Dysphag. improved
8.	AL	F	46	78	150/105	70	Diuresis aft. 6 caps.
9.	GI	F	64	46	180/100	76	
10.	BM	M	54	66	220/110	65	
11.	RS	M	55	60	200/95	60	
12.	LJ	F	59	77	200/105	70	
13.	HM	F	62	84	215/105	80	
14.	WS	M	64	81	190/110	58	
15.	OM	M	64	89	190/105	80	Dysphag. improved
16.	SS	M	66	71	180/90	70	
17.	SG	M	67	49	190/100	90	
18.	WB	M	70	71	185/95	90	
19.	WB	M	71	63	195/95	66	

In 3 patients with esophagal diverticula and achalasia, their dysphagia improved after bromelain administration.

Discussion

We interpret the phenomena as PGE_1 effects. Vane[6] has shown that bromelain partially inhibits the biosynthesis of PGE_2, unlike aspirin, which inhibits it completely. It has also been suggested[5] that the effect of bromelain is due to the stimulation of endogenous PGE_1. Since PGE_1- and PGE_2-type prostaglandins have opposite effects, a partial inhibition of PGE_2, or stimulation of PGE_1, or both, will have the same effect: to increase the relative concentration of PGE_1 in the system. Since both types of prostaglandin compete for the same receptor sites,[7] the relatively excessive PGE_1 will have a better chance of exerting its action. Although the actions attributed to prostaglandins are due also to PG-derivatives and precursors such as prostacyclin, thromboxane A_2, PGG_2, and PGH_2,[8] we are mentioning only PGE_1 and PGE_2, for reasons of simplicity. Our findings confirm also Nakano's observation, that infusion of PGE_1 causes tachycardia and hypotension in all species, including man.[9] Carlson *et al* showed that when PGE_1 was infused in healthy subjects, both heart rate and stroke volume increased, with no change in arterial or central venous pressure.[10]

On the other hand, Boroyan found that a single intra-coronary administration of PGE_1 into open-chest dogs produces a potent and comparatively long-lasting decrease in the resistance of the coronary vessels and in the systemic arterial pressure.[11] The failure of the tachycardia to be accompanied by hypertension may perhaps reflect the balanced effects of increased stroke volume and decreased peripheral resistance, a PGE_1-effect.

Acknowledgement

The authors express their thanks to all persons who participated voluntarily in the study and their appreciation to the Kupat Holim Polyclinic, The Health Insurance Organization of the Israel Federation of Labor in Natania, Israel, on whose premises the test has been carried out.

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JON WON

U. S. Supreme Court affirmed without opinion the ruling of a lower court upholding the constitutionality of the 1974 health planning law. The AMA, the states of Nebraska and North Carolina, and the North Carolina Medical Society had appealed to the Supreme Court after a federal court in North Carolina ruled last August that the law is constitutional, and that Congress can attach any conditions it wants to the distribution of federal funds.

The AMA Annual Meeting Scientific Program, with registration and housing forms, is published in the April 21 issue of JAMA. The meeting is June 17-21, in St. Louis.

Resigning as Director of HEW's Health Planning Bureau, Harry Cain criticized the "bureaucratic swamp" at the agency.

At the Beginning of May, President Carter attacked physicians and the AMA on a tour of the West. In Portland and Spokane, he said that doctors have been the "major obstacle to progress" in getting "a better health care system." The President also criticized the AMA as being only responsible for seeing to the welfare of doctors. The AMA responded immediately in a statement to the wire services that the President's comments are a disservice to the 200,000 physician and medical student members of the AMA and are absolutely in contradiction to the distinguished record of service which the AMA has provided for society.

The Washington Post Newspaper sharply criticized the President's comments in many areas. The Post editorial said Carter "spoke in the familiar sour strain of populism, denouncing the powerful and the worldly." It is the American custom, the editorial continued, to regard the medical arts "with deep dislike and suspicion on all occasions except, of course, when one is sick and suddenly needs them." Bravo!

The American Dental Association filed suit against the FTC under provisions of the Freedom of Information Act to obtain the commission's internal documents relating to dental advertising. The FTC filed a complaint against the ADA and two component societies in January, 1977. The ADA lawsuit seeks FTC minutes, staff memoranda and letters which it believes will be helpful in its defense. The FTC claims the documents are privileged and exempt from disclosure under the Act.

Government Regulations Cost Hospitals $2.98 per patient per day on the average, equal to 1.5% of the average charge to patients. The actual range was $2.29 to $5.78 per patient per day at the six hospitals surveyed for the Michigan Hospital Association by Arthur Young & Company. The government regulations pertain to utilization review, safety and equipment codes, personnel management, arbitration (mandated in conjunction with liability insurance), certificate of need, and reimbursement reporting required by Medicare and Medicaid regulations.

continued on page 148

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Hawaii Internist, Raymond M. deHay, M.D., of Kailua, Hawaii, was given a national Special Recognition award by the American Society of Internal Medicine during its Annual Meeting in San Francisco, May 4-7, 1978. Dr. deHay was honored for his distinguished professional achievements in the field of gastroenterology and for his leadership in the Hawaii Society of Internal Medicine. Our heartiest congratulations to Dr. deHay!



Editorials

Cost Containment

Health care—a most fundamental and personal need—is being examined in a new light. After years of emphasizing access to, and the quality of care, society is now questioning the cost of delivering this service. Health care costs have escalated over the ten year period 1966 to 1976 with annual expenditures climbing from $42 billion to $137 billion, an average annual rate of nearly 11 percent.

Factors other than medical judgement enter into physician decisions as to quantity, type and source of health care. One of these is the economic effect those decisions will have upon both the professional and the institutional provider. Office facilities, manpower, supplies and equipment are purchased by physicians and can be paid for only if the physician is paid. Thus, the factors which affect whether or not the physician is paid (eg, the patient's ability to pay; including the extent of insurance coverage) affect the physician's utilization recommendations. These factors and their relationship to the economic conditions of medical practice are not fully understood and thus it is difficult to propose policies and guidelines in this area. Furthermore, due to the prevalence of third-party coverage in Hawaii of those services over which the physician is likely to have more influence, the patient and physician are not as sensitive as they should be to the cost producing implications of the physician decisions regarding laboratory tests, hospitalization, surgery or referrals to specialists.

Hospitals nationwide have been called upon to contain the annual increase in costs of hospital care during 1978 to a rate that is 2% less than the 1977 increase; and in 1979 to a rate increase of 2% less than the 1978 increase. Physicians are also being strongly encouraged to assist in containing costs of medical care. There are a number of programs that can be undertaken by the individual physician within the health care system that are not dependent upon major changes in the delivery system which will assist in overall cost containment. Examples of two such programs are brought to mind:

- It is argued that there is often duplication of diagnostic tests for a given patient among physicians. One way to reduce this practice is to establish effective quality standards for ambulatory laboratory or x-ray facilities that would enable physicians to rely on previous diagnostic findings when they come to use them in a new setting in order to avoid duplication of expensive diagnostic tests and procedures. It must be understood however, that some highly complex procedures must be repeated in order to assure that the patient receives the appropriate treatment.
- Another area of interest concerns second opinions prior to elective surgery. Studies have shown that the second opinions do not always recommend surgery. However, because there is no evidence to believe that second opinions are more valid than first opinions, these results do not constitute sufficient evidence to conclude that there is excess surgery. But if some surgery is indeed inappropriate, the practice of encouraging patients to obtain an additional opinion may have the potential for reducing unnecessary elective surgery with some resultant cost savings. Third-party payers, working with providers, should undertake conscientious evaluation of the methodologies with coverage of second opinions prior to elective surgery. In a broad sense, physicians are prescribers of health care as they make decisions on behalf of patients. At times physicians may recommend care that is considered inappropriate by their peers because it is not medically necessary or consists of expensive amenities. The decision to prescribe such care can result from patient preference, the form of payment, or physician attitudes regarding current and acceptable medical practices.

These are but two of forty eight areas that the National Commission On the Cost of Medical Care have recommended for consideration by practicing physicians in their efforts to contain costs of medical care.

Your medical association and medical society welcomes your constructive thoughts, innovative ideas, and recommendations on how provider's of health care can further contain the costs of quality health care delivery.

Do we or don't we over-hospitalize?

We, the medical profession, are becoming accustomed to flak—from the news media, from the public, from DHEW and even from the President of the United States. (Flak: The bursting shells from anti-aircraft fire, designed to bring down any one or more of passing aircraft.) It doesn't bother us collectively, because it is not aimed at us as individuals. Our patients, for the most part on a one-to-one relationship of trust and confidence with each of us, are no more represented by "the public," than we are by "organized medicine," ie, the AMA.

The "medical planners" would overthrow the entire existing system of medical care in this country, despite its reputation for excellence world-wide, despite its accomplishments in prolonging the good life by thwarting the devastation of disease, injury, congenital deformity and of aging, and in the very face of man's inhumanity to man and to himself.

These do-gooders, these know-it-alls, would scrap all our gains in health; they would offer, instead, the systems that have already been tried and found wanting in various other societies.

"Doctors over-hospitalize because it is lucrative for them to see a patient for five minutes every day and then charge him an exorbitant fee which, more than 80% of the time, is charged to a third party insurer." This is one of the claims promulgated by our detractors, as an argument to enact laws to reduce the number of hospital beds, to reduce services to patients and to control medical practice. They can't get at the insurers because that would hurt the patient; anyway, the biggest insurer of all is the government, therefore inviolate. They can't get at the patient because, with insured coverage, he could care less about fiscal responsibility so long as he gets satisfactory service.

Is the statement true? Perhaps some of us are guilty of such practices. Perhaps most of us are not. Let's examine the facts.

First of all, the daily visit (or at institutions for lower level of care, the weekly, fortnightly or monthly visits) are mandated by hospital policy. Institutions in turn must comply with the "recommendations" of the JCAH, which itself has become the handmaiden of the DHEW under Medicare and Medicaid, and with which the Blues go very much along. None of us can escape these regulations, much less try to change them.

DSSH (Hawaii) goes so far as to allow a physician a certain fixed payment for his first patient seen in an institution, but a lesser fee for his second and third. Does the patient have any say as to whether he is first or second? No!

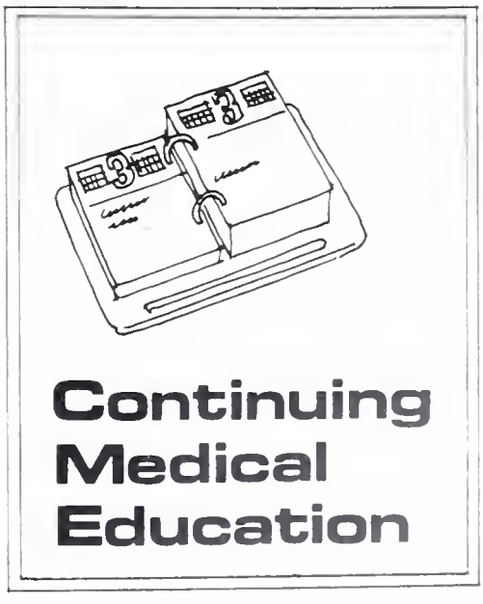
The daily visit may take less than five minutes of patient contact. Yes, but not recognized is the not infrequent lengthy examination and re-examination or conference—usually at no extra charge; the review of X-ray films with the radiologist; the extensive chart work that *must* be completed immediately, if not sooner; the additional paperwork imposed by PSRO and all of government behind that "indentured service without remuneration" scheme; the doctor's time spent with consultants, his time spent on the telephone communicating with hospital staff, with anxious relatives of the patient; his time spent worrying and thinking about a tough case; his time spent on the road to and from the hospital without cover of Workmen's Comp; his not infrequent second and third visits the same day, which are *not* covered by insurance. This listing could go on and on.

No! It is no simple thing to admit a patient to hospital and to follow his progress there. No patient knows exactly how much time his physician devotes to his care in-hospital; no do-gooder ever rides on the doctor's shoulder, (except to harrass him!) to monitor the quantity of his work. Thus, the disincentives for a physician to hospitalize his patient are made obvious.

I don't know about you, my colleague. As for me, I would much prefer to see my sick patient in the working place most comfortable for me, once a year, once a month, once a week if necessary, and even daily if it is for his best welfare, in my office, with my own trusted staff to support me and my own instruments about me. So far, at least, my simple chronological office patient record gets no snooping by PSRO!

The medical planners are probably very, very wrong in their argument.

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w. G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

2. Gynecologic Tutor Oncologist, James Nelson, M.D., Harvard School of Medicine; at various hospitals on Oahu from May 22-29; Kauai—May 30; Maui—May 31; Hawaii—June 1.
3. Tutor Oncologist, Seymoure H. Levitt, M.D., Radiotherapist Univ. of Minnesota; at various Oahu hospitals from June 19-24; Kauai—June 26; Hawaii—June 27; Maui—June 28.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
3. U.H. Cardiology Grnd. Rnds., 1st Tues. 5:30 p.m. Rm. 506 Univ. Tower, Queen's.

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Medical Center

1. Visiting Professor Programs
2. Ophthalmology Departmental Meeting, 1st Tuesday, every month, 1:00-2:00 p.m.
3. G. I. Conference, 4th Tuesday, 8:00-9:00 a.m.
4. Medical Mortality and Morbidity Conference, Department of Medicine Meeting, 4th Tuesday, every month, 1:00-2:00 p.m.
5. Oncology Conference, every Thursday, 7:30-8:30 a.m.
6. Surgical Conference, 1st, 2nd & 3rd Friday, 1:00-2:00 p.m.
7. Surgical Mortality and Morbidity Conference, Department of Surgery Meeting, 4th Friday, 1:00-2:00 p.m.
8. CPC—Surgery, 5th Friday, 1:00-2:00 p.m.

(Contact: CME Dept.-Kuakini for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditiorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

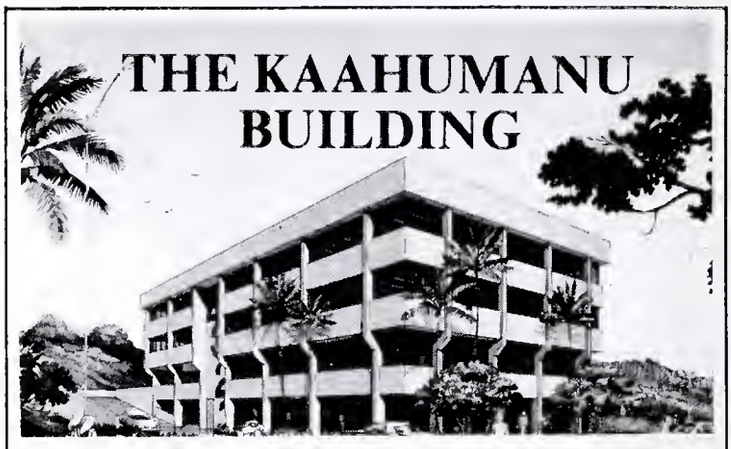
Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
3. Surgical Mortality & Morbidity Conference, 4th Friday, 7:30-8:30 a.m.
4. Dept. of Medicine Monthly Mtg., 2nd Tues. ea. mnth. 7:45 a.m. UH IV Classroom.

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5. Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m.
6. Surgery Sat. Teaching Rnds. (except 4th), 7:30-8:30 a.m.
7. Tumor Conf., every Monday, 7:30-8:30 a.m.
8. Hematology Conf., 4th Thursday ea. month, 12:30 p.m.-1:30 p.m.

Straub Clinic & Hospital

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Cardiac Surgery Meeting meets the 2nd Tuesday of the month, from 4:30-5:30 p.m. in the Doctor's Dining Room.
3. Friday Noon Conference meets weekly, from 12:30-1:30 p.m., in the Doctor's Dining Room.
4. Medical Grand Rounds meets the 1st Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.
5. Orthopedic Conference meets quarterly, from 7:30-9:00 p.m., in the Doctor's Dining Room.
6. Quarterly Professional Meeting meets the 4th Monday of the month, from 7:30-8:30 p.m., in the Doctor's Dining Room.
7. Surgical Mortality and Morbidity meets the 4th Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu
Type: I, 1 hr/day, 1 day/mo from 12 mos
Fee: None Methods: AV, O, Pan
Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: I, 1 hr/day, 1 day/mo for 8 mos
Fee: None Methods: AV, Clin C, O, Pan, R
Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

June 10-17, 1978	USC Schl. of Med.-Radiology. Held at Mauna Kea Beach Htl. Peter Millati, Exec. Dir. Fitzpatrick Travel Serv. 8622 Sunset Blvd. L.A. Calif. 90069.
June 13-20, 1978	Intl. Conf. on Veneral Disease, Family Planning & Human Sexuality. Held at Hilton Hawaiian Village, Honolulu. F.S. Mayer, MPH, R.PH., Exec. Dir. Pharmacists Planning Serv., P.O. Box 1336, Sausalito, CA 94965.
June 17-24, 1978	USC Schl. of Med-Laboratory Management. Held at Mauna Kea Beach Htl. Peter Millati, Exec. Dir. 8622 Sunset Blvd. L.A., Calif. 90069.
June 23, 1978	Toward Comprehensive Lung Cancer Care: An Interdisciplinary Conference, Ala Moana Hotel, contact Kay Van Sant, American Cancer Society, 536-2031.
July 1-8, 1978	USC School of Medicine—Manipulative Medicine, Mauna Kea Beach Hotel, contact Peter Millati, Fitzpatrick Travel Service.
August 5-12, 1978	USC School of Medicine-Ophthalmology, Mauna Kea Beach Hotel, contact Peter Millati, Fitzpatrick Travel Service.
August 12-19, 1978	USC School of Medicine post graduate refresher course, Sheraton Waikiki, Peter Millati, Fitzpatrick Travel Service.
August 26-Sept. 4, 1978	Post Grad. Education for Professionals—U of C Schl. of Med. Held at Mauna Kea Beach Htl. Contact: Barry S. Ramer, M.D., Director, U of C Schl. of Med. Calif. 18 hrs. Cat. I.
Sept. 20-23, 1978	Genetics & the Pediatrician—What Every Ped. Should Know.—Held on Oahu & Maui. Contact: Wilma Schiner, Workshop Coord. Kapiolani-Chldrn's Hsp. 1319 Punahou St., Honolulu, HI 96826 for further info.
Sept. 28-Oct. 7, 1978	Am. Acad. of Family Phys. 1978 Invitational Scientific Congress. Roger Tusken, Exec. Dir. 1740 West 92nd St., Kansas City, MO 64114. Held at Maui Surf Htl.
Oct. 1, 6, 1978	122nd HMA Annual Mtg. & AMA Regional CME Mtg. Ilikai Htl. Ala Moana Blvd., Honolulu. Contact: Mrs. Bess Chang at HMA for further info.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



The Skin You Live In

By Norman Goldstein, in association with Robert B. Stone. New York, Hart, 1978. 205 pp. Price (paperback) $5.95.

This sprightly, sparkling volume of instruction and advice for dermatological patients deserves a sprightly and sparkling review. What it's going to get is a complimentary one.

Though the book is aimed at the lay public, physicians will find it informative, and dermatologists might want to see whether their patients will think the advice in it is consistent with the advice they're getting.

By and large, it is. The author is eclectic in his wide-ranging discussions of therapy, and does not fence himself or anyone else too tightly in. There are 31 illustrations, most of them clear and informative; only

one labelled "fungus infection of the nail" seems inappropriately chosen.

The expectations of success in maintaining youthful and wrinkle-free skin, raised by the author's optimistic and even enthusiastic discussion of this subject, may be unrealistically high, and difficult for patients, or other physicians, to meet; but the advice seems reasonable.

Subjects discussed include, but are not limited to, acne, herpes simplex, herpes zoster, warts, vitiligo (unhappily spelled "vitilito" throughout, no doubt a slip by Mr. Stone), psoriasis, moles and melanoma, dermatitis venenata (the "ubiquitous urushiols" assembled and displayed together, most ingeniously), actinic keratoses and skin cancer, photosensitivity, venereal disease, insect stings, hair loss, scabies, ringworm, and tattoos.

It is the best, simplest, most straightforward book on skin problems for a lay audience, that I have seen. Ten to one you will learn something useful from it, whether you're an MD or not.

HARRY L. ARNOLD, JR., M.D.

A Time to be Born

By David Bell, M.D. Dell, New York, 1975. pp. 189, paperback.
Price $1.95.

This book will not appeal to physicians. Its style is too cute (the blood gas machine used by the residents is called "Tillie" and Dr. Bell talks to it; one baby girl who "sort of looks like a fish" is nicknamed Phreddie-the-Fish Martin); and there is too much attention to the minutiae of activities in a big city neonatology intensive care unit, despite Dr. Bell's disclaimer to the contrary. Many physicians will also object to the glorification of home deliveries, as described in Dr. Bell's delivery of an infant in a commune. Fortunately it was a normal spontaneous delivery.

I doubt that this book will be a best seller.

WILLIAM F. MOORE, M.D.





Jeffrey A. Baysa
MEDICAL STUDENT



James Robert Crowley, M.D.

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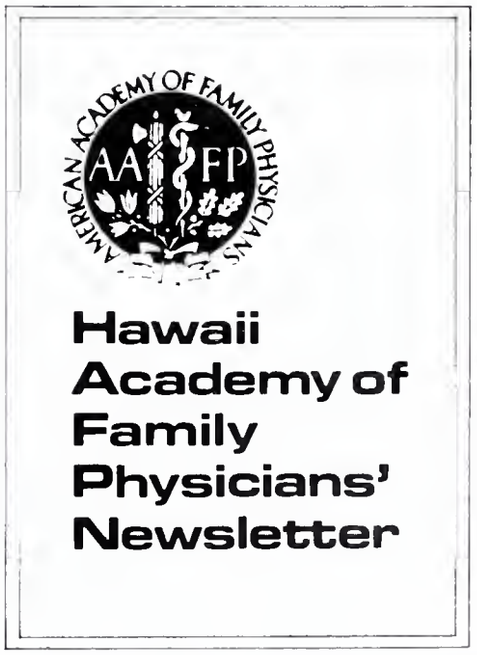
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46-005 Kawa Street
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GENERAL SURGERY



New Members—George Monlux MD is a new Active member who has joined the Kaiser Permanente Group. George has been around for a while, mostly practicing Emergency Medicine. Welcome!

News of Members—H.B. Luke makes 70 this year. The HAFP Council voted to grant him Life membership in advance of his birthday. He has been an Active member since 1965, and is practicing only part-time. We owe a correction to **Howard Liljiestrand** whose wife Betty is being honored by her Alma Mater Grinnell and *not* Cornell, as we misstated in a previous Newsletter, this Summer.

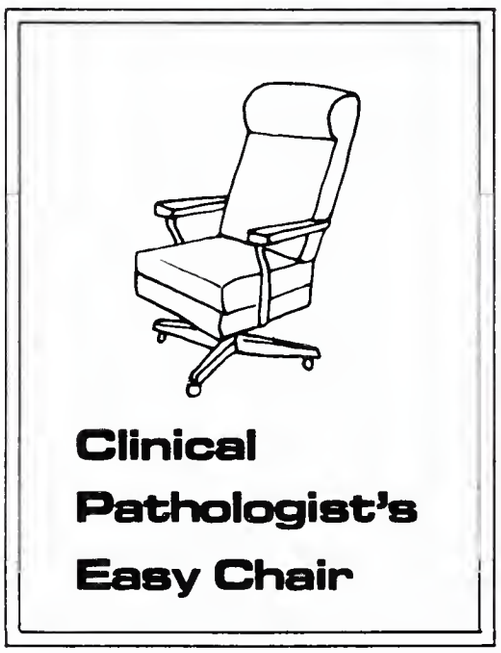
Membership—We have a total of 143 members, of which 63 are Active, 6 Active Exempt, 6 Practicing Affiliate, 7 Inactive, 13 Life, 41 Student, and 7 Resident Affiliate. 29 are ABFP certified, which represents

a little over 20% of our membership. Nationally, there are 11,197 diplomates or 40% of AAFP. There are 335 FP Residency training programs in the USA and more than 100 Departments of Family Practice in U.S. medical schools, including the UH.

G.P.S.A.—Speaking to some 70 members of the General Practice Society of Australia at the Hyatt Regency on 9 April, **Tom Cahill** and **Fred Reppun** presented papers on "Current Office Practice in Hawaii" and "The intervention by Government in the Practice of Medicine" respectively. The dialogue between speakers and a mixed audience of physicians and their wives was lively. Tom & Fred got an earful of Australian "independence" and proclivity to "tell the government off." The GPSA is analogous to our AAPS, which is also far, far "right." Incidentally, a review of our experience indicates that our DSSH is paying physicians at 75% of the 75th percentile, and NOT 100% of the 75th as mandated by the Legislature 1977. Physicians (and hospitals) are the only components of our society that, *de facto*, underwrite the welfare program in Hawaii, which has given the Legislature and the Governor fits over its cost override.

Medicare Snafu—speaking of government in medicine: How many of you noticed in the Star-Bulletin (3/15/78) that DHEW spent $122,000 to correct the errors in its listing of physicians making more than $100,000 a year, which listing cost DHEW only $14,000?

CME—The HAFP Council, by a bare majority, voted to have **Pat Dietrich** tell AAFP at the State Officers Conference that Hawaii is confused about Category "P" credit versus AMA's Category 1, and wishes the AAFP to try to bring about a more logical relationship with AMA, or embark upon a totally new concept of educational criteria for continued membership in AAFP. We remind you of goodies coming up: CCR for 32 "P" over 8 months starting 1 Oct 78; USC-UH-Tripler PG Refresher 12 to 23 August; Georgia AFP's "Primary Care Review—Home Study Course" starting 1 Sept with enrollment deadline 5 June; AAFP & ACOG joint "PG Course in Obstetrics" 14, 15, 16 July in San Diego for $175, enrollment limited.



Bilirubin

Bilirubin is the degradation product of hemoglobin with small amounts from other nonheme porphyrins. It is formed in the reticuloendothelial system and carried by albumin to the liver where it is conjugated with glucuronic acid and excreted into the intestinal tract via the bile canaliculi and excretory duct system. Most of the bilirubin is converted to urobilinogen by the intestinal flora, but a small fraction is hydrolyzed and reabsorbed.

The normal liver efficiently disposes of bilirubin from the blood and maintains a serum level of less than 1 mg per dl. Clinical jaundice is usually noted when the serum level is greater than 2.5 mg per dl. Van den Bergh discovered two types of diazo reactions when he added Ehrlich's reagent to sera from jaundiced patients. The color developed within 30 seconds in the serum from a patient with obstructive jaundice and he called it direct bilirubin; the serum from a jaundiced patient with hemolytic anemia required addition of alcohol for color formation and he called this indirect bilirubin. It has been shown that the indirect-reacting bilirubin is unconjugated or 'free' bilirubin, while the direct-reacting portion is made up of bilirubin diglucuronide and a 1:1 mixture of 'free' plus the diglucuronide.

Since bilirubin is conjugated in the liver parenchymal cell and excreted by the excretory system, conjugated bilirubin should not leak into the blood from the normal liver. The liver cells retain their ability to conjugate bilirubin in liver disease, but much of this conjugated form leaks into the blood. There theoretically should not be any conjugated bilirubin in the blood of normal individuals, but there is a small amount detected due to the nonspecificity of measurement of conjugated bilirubin. With most accepted methods, the conjugated fraction (direct bilirubin) should not exceed 0.30 mg per dl.

continued on page 156

"We Bring People Together"

PERSONNEL-ITY OF THE PACIFIC

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Paul S. Isenburg

Paul S. Isenburg, PhD.
Director
Medical Division

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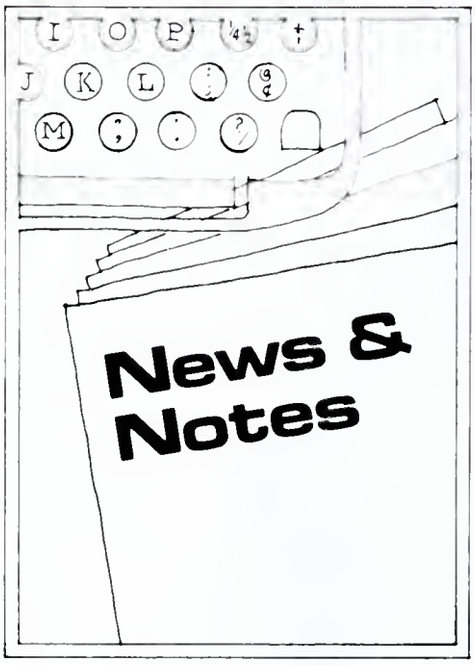
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Increase of bilirubin concentration occurs as a function of fasting. Total serum bilirubin begins to increase 5 to 10 hours after the last meal and increases progressively. In normal individuals, the increase after a 48-hour fast averages 240%, and in patients with hepatic dysfunction such as Gilbert's syndrome and cirrhosis, the average increase is 194%. The diurnal rhythm of bilirubin, with the highest levels in the mornings, is related to the overnight fast and it can be suppressed by frequent nocturnal feedings. A 48-hour fast is not unusual in very sick patients, especially after surgery.

Bilirubin may also be increased in septicemias, following strenuous exercise, alcohol ingestion, some cases of pregnancy and in some patients who use oral contraceptives. Jaundice may occasionally complicate major surgery. There are many possible causes such as transfusion of stored blood which invariably begins to hemolyze within 24 hours especially if more than two weeks old, hepatocellular impairment due to anesthesia, drugs, shock, hepatitis and sepsis.



HENRY N. YOKOYAMA, M.D.

Professional Moves

The Equine Year started with a furious gallop and simply ran out of steam . . . In April ophthalmologist **George Plechaty** opened full time at the Waianae Mall Shopping Center and gastroenterologist **Edward Bourke Jr.** moved into Suite 510, Queen's Physician Bldg . . . On the Big Island, FP **Charles Morin** joined the Waimea Medical Associates at Lucy Henriques Medical Center, Kamuela, and **G.Y. Tomoguchi** announced that he was retiring as of June 21. On the Garden Isle, pediatrician **Linda Weiner** joined the Waimea Clinic where husband **Robert Weiner** is a surgeon.

Personalities

"**Dr. Ron Pion** is a gregarious, 'Hey, wow!' sort of guy who is supremely confident that his latest book, 'The Last Sex Manual' will not only land on the best seller list but will climb all the way to the top of the charts . . . The approach is something between the Ladies Home Journal's 'Can This Marriage Be Saved?' monthly feature and the erotic diaries of Anais Nin . . . Ron feels It's Norman Vincent Peale about sex. It's about being positive and being gets to be another word for behavior . . . In general, most of what is done between human beings is all right . . . Being positive is something Ron has no problems with: 'I say to myself: Ron, you're truly wonderful and remarkable . . . And I say it to myself every morning.'"

(Extracted from the *Star Bulletin* feature by Barbara Morgan) (*Ed:* We agree a 100% that Ron is a 'truly wonderful and remarkable' guy for he has been moderating our weekly HMA ½ hour TV show, 'Health Conversation' or 'Your Body, Your Mind' for the past 2 years, sans rehearsal and sans preparation . . .)

Following in the wake of his successful book, "The Skin You Live In," dermatologist **Norman Goldstein** plans a book on tatoos . . . "Tatoos are making a come back. In the past 4 months, I've had 4 girls come into the office with little tatoos on their buttocks." (Daacon)

Poor **Jack Scaff** . . . Holiday Tour's Paul Diller celebrated with a 3rd Floor dinner after winning a bet from Jack . . . "If Diller finished the race more than 45 minutes after Scaff, he would have owed Jack and Donna a free charter flight to Europe, but he came in only 25 minutes after. At the finish line, Diller offered a long faced Scaff some Dom Perignom champagne which Jack declined—settling for some beer to cry in . . ." (Daacon)

Entrepreneurs

Senator Yamasaki is asking for a $3 billion appropriation for the construction of a Makena State Park and **Edwin Kam** of Kailua who owns 88 acres of Puu Olai, Makena, Maui is the principal land owner. Edwin has proposed that the State lease the land with an option to buy . . .

DSSH statistics show that of the 1,247 physicians receiving Medicaid earnings, 60% of the physicians received less than $10,000 and 43% earned less than $5,000. Only 7 medical clinics and/or individual physicians earned more than $100,000. We agree with indignant radiologist **Phil Lee** who commented, "I feel as though I am getting one big slap on the hand . . . Any physician who treats Medicaid patients is performing a public service and publishing the Medicaid earnings creates in the public mind an image of wrong doing, and underhandedness that isn't justified . . . Even though the rate of Medicaid reimbursement was increased in 1976, physicians are taking a substantial loss by treating Medicaid patients . . . The fee schedules are set 5 years behind the times . . ."

Bulletins

The Public Health Committee of the Chamber of Commerce of Hawaii has awarded the HMA TV-Radio Committee $15,000 for continued production of the ½ hour program "Health Conversations" which appears on cablevision throughout the State. Credit goes to **Phil McNamee,** our dynamic HMA Commissioner of Public Affairs . . . "Health Conversations," previously called "Your Health, Your Mind" when produced at Punahou School, is moderated regularly by **Ron Pion** and **John Corboy** . . .

The Chamber of Commerce of Hawaii also awarded $5,520 to the American Diabetes Association of Hawaii for a training, education, outreach and screening program on Oahu . . .

Elected, Honored & Appointed

Pac PSRO reelected **Winfred Lee** president, **Rodney West** vice president, **Murray Berger** secretary and **Robert Willcox** treasurer . . .

Edgar Hauntz whose forte is diabetes was awarded an honorary degree of Doctor of Science from the University of North Dakota for "his contributions to medicine and his service to humanity." Edgar, *professor emeritus* of medicine at U of North Dakota Med School, spends half the year in Kona with the Kona Coast Medical Group and the other half in Grand Forks, N. Dakota . . .

Ralph Hale, chairman of the OB Gyn Dept, John Burns Medical School has been elected VP of the 357 member Association of Professors of Gynecology and Obstetrics . . .

Urologist **William Davis** was reelected president of the medical staff, Rehab Hospital of the Pacific at its 3rd Annual Meeting. **Fred Shepard** is VP-medical . . .

The HMSA elected **Stanley Saiki** secretary and **Peter Kim, Henry Oyama** and **Ann Barbara Ho Yee** board members . . .

The Honolulu Sertoma Club's 3rd Annual Freedom Award winners include **Francois Saculla** for medicine . . .

Sportsmen

Runners: Straub orthopod **Gerald Mayfield** journeyed afar to the Boston Marathon . . . To his utter dismay, he found that besides 4,000 registered entrants, another 2,000 unregistered also ran . . . So crowded was the line up, it took Gerald a full 7 minutes just to cross the starting line . . .

Jim Gallup, 42, Honolulu Medical Group pathologist, started running in 1974 . . . Recently, in a 28 day period, he logged 90.5 miles of racing and another 400 training miles sandwiched between . . . On March 5, Jim placed 3rd in the 5 mile Mid Pacific Road Runners Club meet . . . Next week, he finished 2nd among 400 participants in the 8th Annual Maui Marathon . . . Two weeks later, Jim finished 2nd among 800 competitors in the Norman Tamanaha Memorial 15 kilometer (9.3 mile) race and finally on April 7, he won the AAU 50 mile race at Schofield Barracks with a time of 5 hours 52 minutes, 3.8 seconds . . . Describing the ordeal of the 50 mile run, Jim says, "During the second half, the bandaids peel, the vaseline dries, the feet swell, the shoes shrink, the accumulated salt chafes, the sun burns, the eyes blur, thirst becomes extraordinary and the onlookers seem to become hostile . . . The fat is on the fire and discomfort prevails . . ."

In the 4th Hawaii International Masters Track and Field Ho'ohuku, **Sharon Bintliff** was expected to battle a Virginia Moore head to head in the woman's pentathlon starting with the 100 meter low hurdles and ending in the 800 meter run . . .

Michael Savona who with **Robert Moser** organized "Run for Your Life" (the cardiac rehab program on Maui) in the fall of 1976 says, "Exercise is not going to cure the disease responsible for the heart condition, but will strengthen the heart muscle that is left and make the muscle more efficient." The program has 30 Maui residents all 40 years and older . . .

Paddlers: **Howard Keller, Ed Dierdorff** and **Phil Foti** are the physician members of the 7 man crew from the Ohana O Waalele canoe club of Lanikai which will paddle an outrigger canoe across the English Channel and up the Thames River into London in June to celebrate the 250th birthday of Capt Cook. They were invited by the British Royal Navy and the Captain Cook Trust . . .

Cheer leaders . . . Hilo physician **Ben Hur** and Hilo college economist Young Khi Hahn are the popular, but unofficial cheer leaders for the Hilo Vulcans . . . They use a unique rhythmic group cheering technique they learned in their native Korea and delight everyone with their antics, except their embarrassed wives who refuse to attend the basketball games . . .

Fast Woman . . . Director **Jack Scaff** has invited Margo St James, head of the San Francisco prostitute's union, Coyote, to run in the next Honolulu Marathon. "Margo, who used to be a marathon runner before she stared running around with the wrong crowd, has responded, 'Yes.' Says Scaff: "She may not win the Marathon, but Margo is sure to be the 'fastest woman' in the race." (George Daacon, Apr 10)

Miscellany

A Red China delegation of three was on an inspection tour of restaurants in America. While two members were overwhelmed by the shiny stainless steel fixtures and the convenient mechanical devices, the third member kept peering into the restaurant garbage cans and muttering, "Americans so wasteful . . ." An Irish couple was having a typical friendly squabble. He smacked her in the kisser and she fell backwards landing in a garbage can . . . Just then the third member came out the restaurant rear door, and found her dazed and still in the can . . . "Ah, Americans so wasteful . . ." he shook his head, "She still good." (As told by our favorite humorist-song and dance man, **Ed Kagihara** who MC'd the Pearl City Medical Associates' banquet for new member **Fred Tanabe** at HICC and honoring their "godfather" **Joe Nishimoto.**)

Hors De Combat

Inflation Control? Barry Bosworth, director of the Council on Wage and Price Stability reported that "the Carter Administration plans to call in doctors, dentists and lawyers to urge that they hold down their fees in line with President Carter's effort to control inflation."

Sensationalism? HEW Secretary Joseph Califano warned that 51% of the 8 to 11 million Americans who worked with asbestos during and after WWII may die of lung cancer or asbestos related diseases. He reported that these diseases take 15 to 35 years to develop and that exposed smokers are 30 times more likely to develop lung cancer than exposed nonsmokers . . . In the wake of the announcement, 4 cases among PHNY workers were reported to the federal Office of Workers' Compensation (OWC), one of which was lung cancer . . . Hawaii Cancer Research Center's Lawrence Kolonel reported that an on going study of 9,000 PHNY shipyard workers since 1950 indicates that exposed workers may have only a slight increased risk of lung cancer . . .

Cost Containment??? Following the February announcement by the Hospital Association of Hawaii (HAH) that a Voluntary Cost Committee will attempt to cut back last year's 15% health cost increase to 2% per year, QMC announced a 13% increase and Kaiser an 11 to 12% increase effective July 1 . . . Frustrated DSSH director Andrew Chang stated that the raise will push the Medicaid budget at least $1.3 million over the appropriation allocated by the recent legislature. "I'm dismayed and disappointed that only less than 2 weeks after the legislative session closed, this announcement comes out," Andrew points out that the program has ballooned in just a few years from $42 million annually to 95 million this year . . . "Big Deficit Puts Molokai Hospital in Intensive Care." Molokai General ran a $144,000 deficit during the 1977 fiscal year despite a $270,000 subsidy from the State. Yet it still managed to avoid losing its independent status as a community hospital by affiliating with St Francis Hospital in Honolulu. Now it can use St Francis' computers for billing and its consultant services and make joint purchases of supplies.

Someone Goofed? A 5th Circuit Court $200,000 suit against defendants **Charles Custer, William McLaughlin, Arnold Nurock,** the Waimea Dispensary and the Kauai Medical Group was withdrawn by the Lihue lawyer who filed it. The suit had charged that the physicians had misdiagnosed a condition later supposedly found to be meningitis by Wilcox Hospital ER physician **Michael Cicero** . . .

EMS Emergency . . . A last minute House attempt to cut a bill for EMS training led by Big Island representative Herbert Segawa, Chairman of the Health Committee was defeated . . . Segawa proposed slashing $540,000 from the $727,000 bill. **Biff Dang,** EMS director, and others testified that the house cut would eliminate services to neighbor islands, damage the instructional team and impair eligibility for future federal aid. Our thanks to Senators Pat Saiki and Anson Chong who fought tooth and nail against the cuts in staff and neighbor island services . . . The budget was finally compromised at $687,000 as a direct grant to the HMA, effective July 1, 1978 . . .

Our favorite letter writer, **Fred Reppun,** complained to John Sheedy, DHSS medical consultant about the requirement for semi-annual complete physicals and monthly certification of orders on his 100-year-old senile, bedridden patient in CCH. Fred fired a broadside against what he regards as "petty, bureaucratic, silly and dangerous requirements of the Medicaid and Medicare programs." "Are the Feds afraid she might become young again, get up and walk, and cheat them by no longer requiring that level of care?" Poor John. He is the best and fairest medical consultant DOH has ever had and we hate to lose him . . . He defended the requirements, but agreed Fred had a point and is sending

a request to San Francisco Regional Office to consider a waiver in this case . . .

Chief of FDA, Donald Kennedy estimates that 30% of all diagnostic Xrays are unnecessary, but are ordered out of concern about professional and medico-legal consequences of failure. In 1977, Americans will have 241 million Xrays costing $6.3 billion and he begrudges the unnecessary cost and radiation exposure to the patients . . . (Ed: But he would be doing likewise, if he were a practicing physician . . .)

This is the season for law suits against fellow physicians, it seems . . . Hilo physician **Kenneth Robert Hughes** who recently resigned as Hilo Hospital director filed a $600,000 damage suit against Kona physician **Allan Hubacker** who "damaged his reputation and invaded his privacy" in a letter sent to Henry Thompson, deputy DOH director, **Ernest Bade,** Hilo Hospital chief of staff and **James Williams,** Hawaii County Medical Society president . . .

Another lawsuit filed by city pathologist **Al Majoska** against Willis Butler for $300,000 (for Willis' critical letters published in the Star Bulletin re the autopsy performed on the late Fitisemanu Moe) were thrown out by Judge Arthur Fong who ruled that there was no malice shown by Willis . . .

Richard You whose license was revoked on Feb. 9 by the nine-member Board of Medical Examiners was granted a 45 day stay by Circuit Judge Arthur Fong while he appealed his case to the Supreme Court. Richard's license was revoked for excessive prescription of dangerous drugs after 13 days of closed hearings in September last year . . .

"Physician Heal Thyself" A University of Pennsylvania study revealed that 46% of senior medical students suffered from major emotional handicaps such as severe anxiety, depression and obsessive compulsions, because of the intense competition to get into medical school and to survive. Another study shows that after graduation, ½ of the doctors had had marriages, ⅓ sought relief in drugs, and ⅓ underwent psychotherapy . . .

The senate proposal for allowing the use of marijuana for specific medical purposes was supported by the Legislative Concerns Committee of the Hawaii Council of Churches . . . Testimony against the bill came from the DOH, the Maui County Council, HPD and the HMA . . .

Life in These Parts

Computerized Billing and Hospital Rate Increase: QMC will raise its rates 13% as of July 1. The previous rate increase of 14% was last July 1. Salary increases for 1,400 employees, inflationary costs of hospital supplies and the need to revolutionize the computerized accounting system (which will cost $500,000 to $1.5 million) were reasons given.

HDL & Exercise: Cardiologist **Alfred Morris** of the Honolulu Marathon Clinic Research Committee feels that long distance running increases high density lipoproteins which prevent heart attacks . . . The project committee is looking for volunteers, viz men ages 35 or older, who are not currently running, but are willing to begin a jogging program of 15 minutes 3 times a week and progressing to 30, 45 and 60 minutes 3 times a week and who are willing to continue the program for 6 months without changing eating, drinking or smoking habits during the period . . .

Thumb replanted . . . Orthopod **James Doyle,** who does microsurgical techniques at Queen's and who has done a number of finger replants in California, successfully replanted the thumb of Kapaa rodeo rider Roy Campos Jr which was jerked off by his rope when practicing cow punching . . .

Cancer Cell Inhibitor . . . Leighton King retired to Kihei in 1972 after 30 years as chief research scientist for a technical research company, but he continues to work 40 to 50 hours a week in a small room at the Lahaina Storage Depot. The National Cancer Institute recently reported that of the more than 700 tissue cultures of marine specimens he had sent in, two forms of corals and the red sponge from Maui waters showed promise as cancer cell growth inhibitors. Leighton is also studying methods of stimulating the growth of damaged spinal nerves and the ability of marine animal extracts to break down blood clots . . .

Death Legalized . . . Legislators could not agree on a "living will" bill which would direct physicians to stop life sustaining treatments in patients with severe suffering or irrationality, but did agree on a bill to stop artificial life support for comatose patients with "irreversible cessation of spontaneous respiration and circulatory functions" and "when brain function is irreversibly ceased (as determined by a neurologist or neurosurgeon)."

Po'ou Poisoning . . . On the Big Island, DOH epidemiologist Chester Wakida reported 12 cases of *ciguatera* poisoning thus far this year as compared to 10 cases in 1977. District health officer Andrew Sackett describes the symptoms of *ciguatera* poisoning to include diarrhea, chills, headaches and confusion of temperature sensation and itching. There is no standard therapy . . .

The Great Hysteria . . . In the wake of the recent Hollywood report on increased uterine cancer from estrogens, **Frederick Hofmeister,** Wisconsin Med School OB Gyn Clinical professor, reported at the 14th Pan Pacific that of the 22,000 endometrial biopsies he and 4 other colleagues have done since 1949 on high risk women, only 241 cases of uterine cancer were diagnosed. Of these cancer cases, only 26% had taken hormones while 66% had not. The remaining 8% did not know. He feels that the greater incidence of uterine cancer in the last few years may be a sign of greater physician awareness, rather than the result of hormone therapy . . .

Federal Funds for EMS . . . Senator Pat Saiki returned from a national meeting of HEW officials and municipal emergency service program directors and is optimistic that we may get a $400,000 federal grant for the first year of our statewide EMS program.

Rugby Anyone? Jack Keenan, the Irishman from the old country who emigrated to Hawaii in 1964, is responsible for the popularity of rugby locally. Jack will coach the Hawaii team representing the US in the prestigious 3rd Annual Rothmans-Cathay Pacific International Seven-a-Side Rugby Championships in Hong Kong. Jack, in his brogue said, "It's a tremendous honor for Hawaii . . . We were picked over US mainland teams and will be competing against the best of 15 other countries."

Hawaii Licensure Exams Too Difficult? Charumati Rao, a naturalized citizen of 27 years with an MD from Prince of Wales Medical College in India and the University of Pennsylvania, is licensed to practice in Montana and Washington State . . . But alas! She twice failed to pass the Hawaii licensure exams. By March 17 Charumati had fasted 15 days and vowed to continue fasting until legislators eased the licensing laws in Hawaii (Shades of M. Ghandi!!)

Our "Angels"

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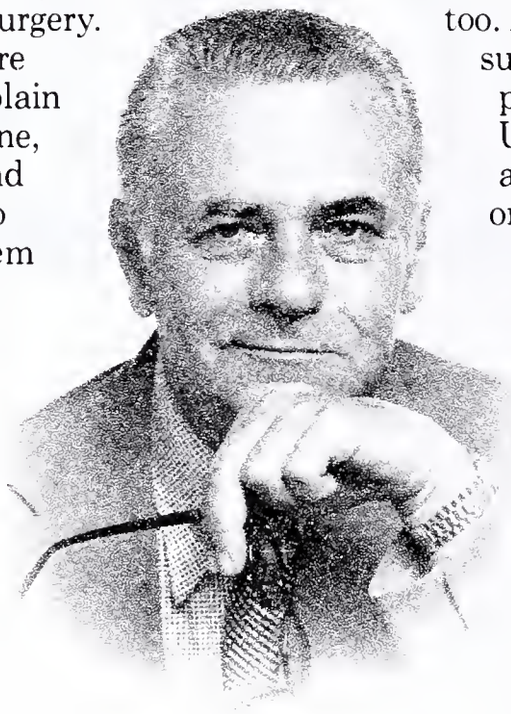
From what our HMSA members tell us, more doctors seem to be perfecting that old fashioned 'bedside manner.'

To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk about these important matters.

We think these are both healthy signs. We can all do our part to promote this kind of helpful dialogue.

We'd like to hear from you, too. Anytime you have a suggestion or question, please let us know. Usually we can have an answer for you in a minute or two.

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Old Fashioned Dialogue is Back.

HMSA Utilization Review Department
Ph: 944-2355

HMSA

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VOL. 37, NO. 6

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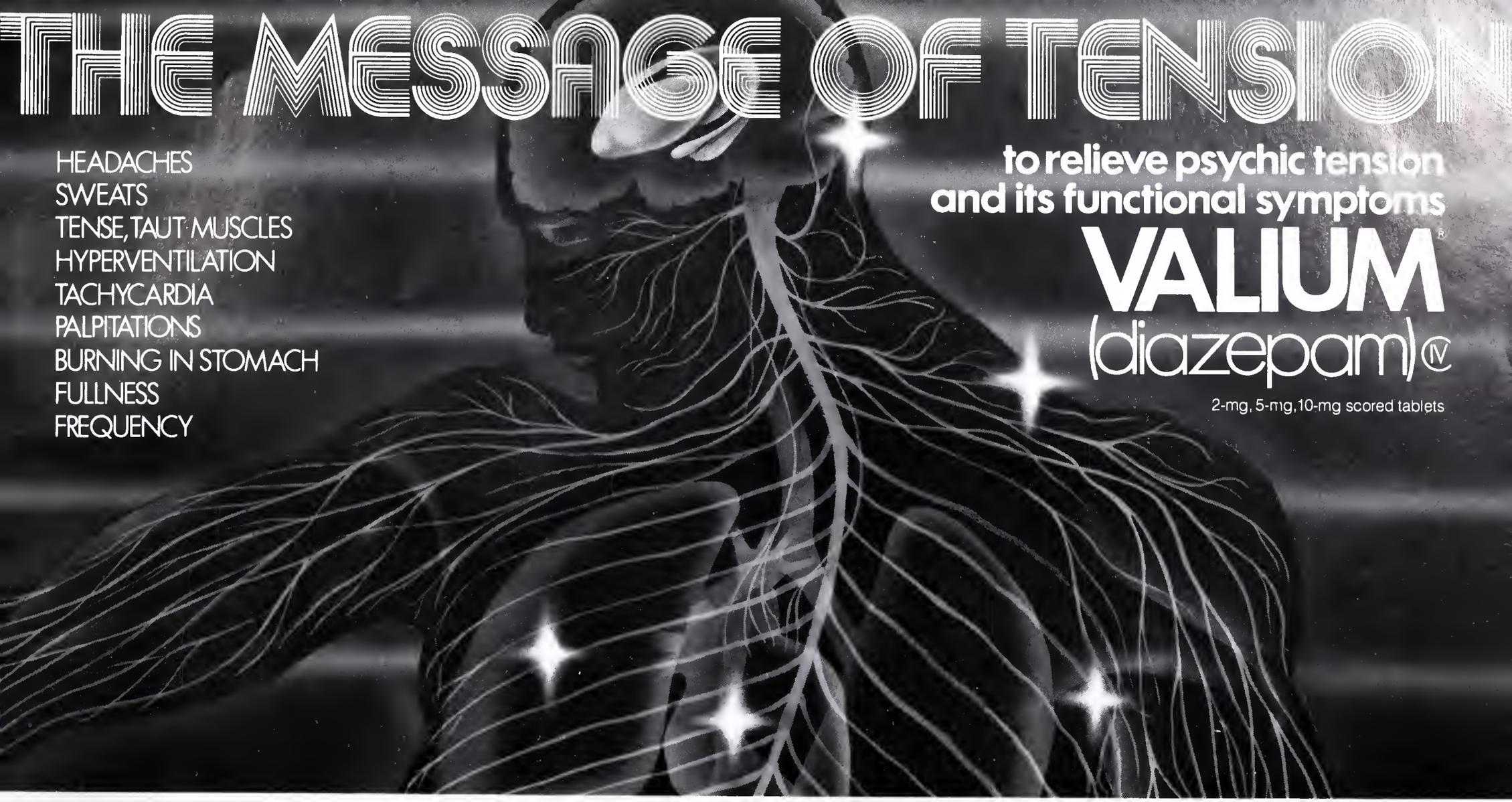
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Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy

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COLBY PROCLAIMS WOMAN SUFFRAGE

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MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are



WASHINGTON, Aug. 26, 1920—

Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000 Persons When States Adopt Cooperating Laws–He Co the Measure 'Cornerstone' of His Economic Program

WASHINGTON, Aug. 14, The Social Security Bill, pro a broad program of unemplo insurance and old age pe and counted upon to benefi 20,000,000 persons, became l day when it was signed by dent Roosevelt in the prese those chiefly responsible fo ting it through Co[illegible].

Mr. Roosevelt call[illegible] the m "the cor[illegible]erstone in a str which is being [illegible] me[illegible]s comple[illegible]

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved [illegible] today, 94 to 0, and sent [illegible]

TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

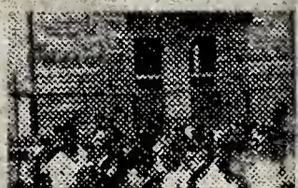
The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

IGNE the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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7% of the population may be harboring latent or dormant tuberculosis*

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Stead, W.W. and Bates, J., in Harrison's Principles of Medicine,
8th Edition, 1977, McGraw-Hill, p. 900.



LEDERLE Tuberculin, Old

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Precautions: Tuberculin testing should be done with caution in persons with active tuberculosis. However, activation of quiescent lesions is rare.

Although clinical allergy to acacia is very rare, this product contains some acacia as a stabilizer and should be used with caution in patients with known allergy to this component. Reactivity to the test may be suppressed in patients who are receiving corticosteroids or immunosuppressive agents, or those who have recently been vaccinated with live virus vaccine such as measles.

With a positive reaction, further diagnostic procedures must be considered. These may include x-ray of the chest, microbiologic examinations of sputa and other specimens, and confirmation of the positive TINE TEST using the Mantoux method. In general, the TINE TEST does not need to be repeated. Antituberculous chemotherapy should not be instituted solely on the basis of a single positive TINE TEST.

Adverse Reactions: Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons. Pain, pruritus and discomfort at the test site may be relieved by cold packs or by a topical glucocorticoid ointment or cream. Transient bleeding may be observed at a puncture site and is of no significance.

Reference: Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N.Y. 1969

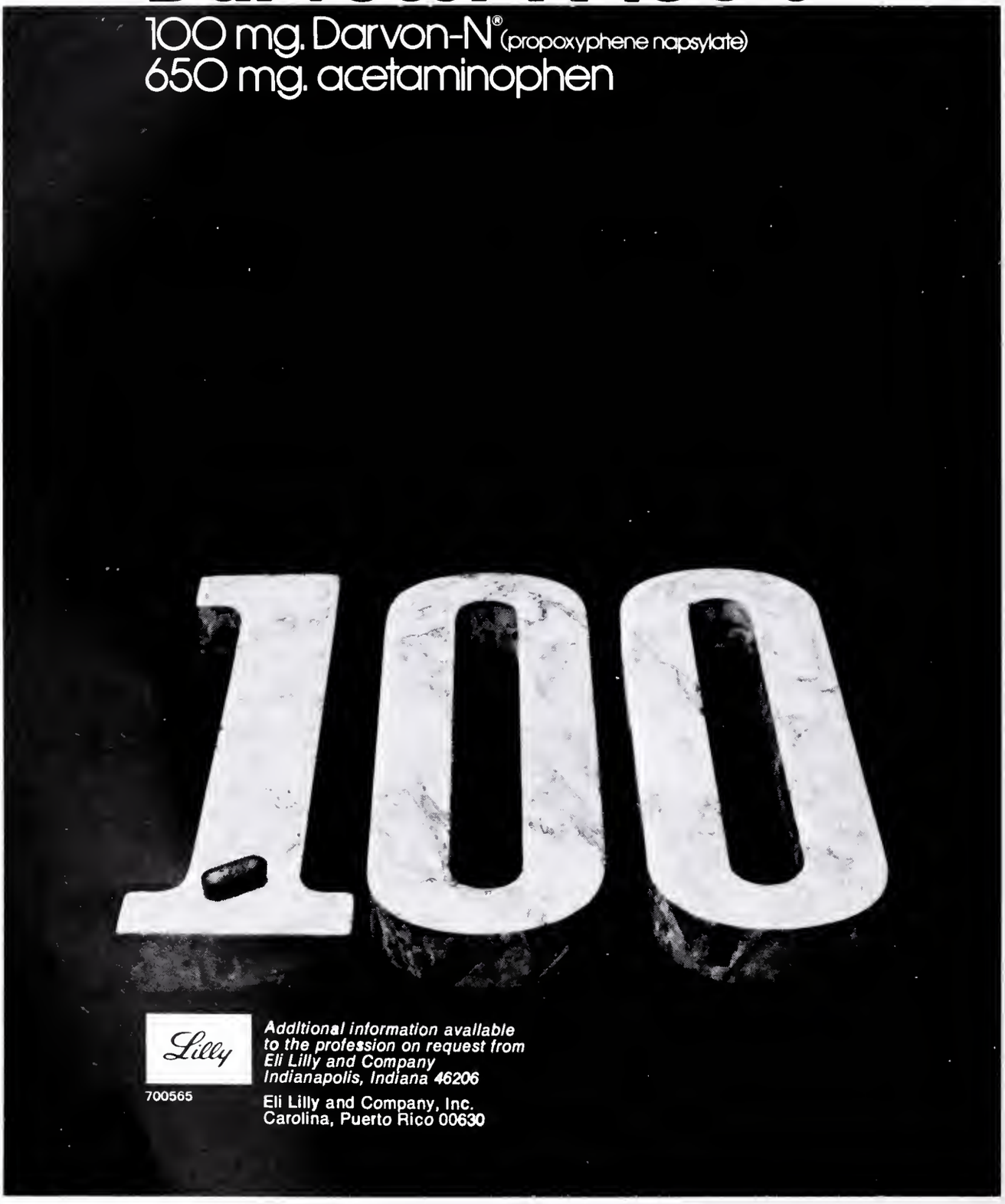
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"Hyskon Hysteroscopy": A Preliminary Report

KUNIO MIYAZAWA, M.D.,* *Honolulu*

• *The use of hysteroscopy in gynecological practice has an historical background of nearly a century. The introduction of 30% dextran media in 1970 resulted in various gynecological applications in diagnosis and therapy, as well as multiple research programs in hysteroscopy. Hyskon (dextran) hysteroscopy in gynecological practice is safe and of value. It is a definite adjunctive tool when used in conjunction with D&C and laparoscopy.*

Although endoscopic study of the uterine cavity has been available for about a century, very few gynecologists have utilized the hysteroscopic procedure. Since 1970, when Edstrom and Fernstrom[1] introduced a new technique for hysteroscopy using 30% dextran for uterine distention, various clinical reports have appeared in the literature.[2,3,4]

Materials and Methods

From September, 1976, to April, 1977, a total of 31 hysteroscopic procedures were performed in the gynecology department of Tripler Army Medical Center. All procedures were performed in an operating room under general anesthesia, except for one under local anesthesia. These were in conjunction with 31 D&C's and 3 laparoscopies by one of the resident staff or teaching staff and the author. The patients' ages ranged from 22 to 60 years. Although most of the patients were mothers, 8 patients (26%) were nulliparous, as shown in Table 1.

TABLE 1.—*Age And Parity Of Patients Hysteroscoped*

	PARITY					
AGE	0	1	2	3	>3	TOTAL
20-29	4	2	1			7
30-39	2	1	2	1		6
40-49	1		5	2	3	11
50-59	1	2			2	5
>59				1	1	2
Total	8	5	8	4	6	31

*LTC MC USA, Assistant Chief, Department of Obstetrics and Gynecology, Tripler Army Medical Center, P.O. Box 307, Honolulu, Hawaii 96859

The opinions or assertions contained herein are the private views of the authors and are not to be construed as offical or as reflecting the views of the Department of the Army or the Department of Defense.

The most common indication was abnormal uterine bleeding with normal pelvic examination, in 80% of the cases. Other indications included infertility work-up with abnormal hysterogram and lost IUD.

After a bimanual pelvic examination was completed, the uterus was sounded and the cervix grasped with the tenaculum. When there was abnormal uterine bleeding, endocervical curettage was done. The cervical canal was dilated to 7 mm., and the Wolf Lindemann-Semm's hysteroscope inserted slowly. With the instrument in place, Hyskon (32% dextran 70)[5] was infused slowly to distend the uterine cavity; care was taken to avoid bubbling and overdistention. After the uterus was distended, a careful systematic viewing examination followed and findings were dictated, graphed, and, in some instances, photographed. Every attempt was made to schedule the case during the proliferative phase of the menstrual cycle, as suggested by some authors.[6,7,8] After abnormal hysteroscopic findings were appreciated, curettage followed, especially over the abnormal areas. In cases where polyp or polypoid lesions were found, repeat hysteroscopic examination was performed after curettage to ensure complete removal of the abnormalities.

Results and Discussion

Of 31 patients, 21 (67%) had abnormal hysteroscopic findings. In 25 cases of abnormal uterine bleeding, 16 patients (64%) had abnormal hysteroscopic findings. In all infertility cases with abnormal defects on hysterogram, synechiae were seen.

Table 2 shows hysteroscopic findings according to age. "Polypoid lesion" refers to a broad-based irregularly shaped, rather shaggy lesion. A similar lesion was previously called by Edstrom and Fernstrom a "broadbased irregularly shaped polypus" as shown in Fig. 1.[1] A typical example of a "polypoid lesion" is shown in Fig. 2 which is taken from one case of this hysteroscopy study group.

The over-all hysteroscopic findings were correlated with the tissue histopathological diag-

TABLE 2.—*Age And Hysteroscopic Findings*

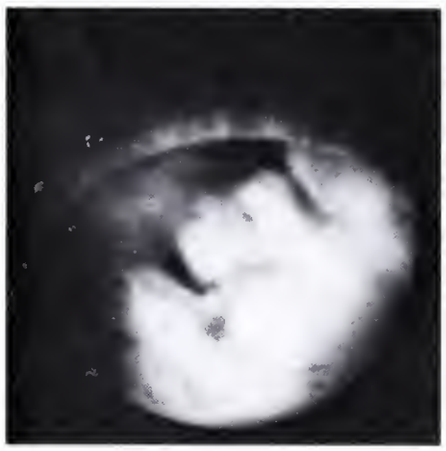
AGE	HYSTEROSCOPIC FINDINGS						
	POLYP	POLYPOID LESION*	SUBMUCOUS MYOMA	SYNECHIAE	IUD	NORMAL	TOTAL
20-29	1	1		4	1		7
30-39	1	1		2		2	6
40-49	2	3	2		1	3	11
50-59		3				2	5
>59	1					1	2
Total	5	8	2	6	2	8	31

*See Fig. 1 and 2

FIG. 1.—*A broadbased irregularly shaped polypus.*[1] *Courtesy of Drs. K. Edstrom and L. Fernstrom*



FIG. 2.—*Case #A.L. Irregularly shaped, shaggy multiple polypoid lesion on posterior wall of uterus*



noses on curettage in 77% of the cases concerned. The abnormal hysteroscopic findings yielded 68% correlation to histopathological diagnosis, but the normal hysteroscopic findings yielded 90% correlation to the histopathological diagnoses. As seen in Table 3, the common abnormal hysteroscopic findings for abnormal uterine bleeding were polyps or polypoid lesions. Their abnormal pathological findings on curettage appear to reflect a fairly close relationship of the polyp or polypoid lesion to endometrial hyperplasia. Normal hysteroscopic findings for abnormal uterine bleeding seem to indicate good correlation with normal pathological findings on curettage.

The amount of Hyskon used for the procedure ranged from 30 cc. to 100 cc., with an average of 45 cc. for each case. No complications were encountered by this procedure.

Conclusion

A total of 31 hysteroscopies were performed, using Hyskon (dextran) as the media. Hyskon hysteroscopy has been found to be a very valuable and safe gynecological adjunctive tool, not only identifying and locating unexpected or unsuspected intrauterine pathology, but also in confirming suspected pathology. The procedure is especially useful in conjunction with such procedures as D&C and laparoscopy.

TABLE 3.—*Hysteroscopic And Pathological Findings For Abnormal Uterine Bleeding (Total 25 cases).*

HYSTEROSCOPIC FINDINGS	ENDOMETRIAL PATHOLOGY FINDINGS
Normal—9	Normal—8 Abnormal—1 (mild adenomatous hyperplasia)
Abnormal—16	Normal—6 Abnormal—10
1) polyp—5	normal—1 (endometrial polyp—2) (adenomatous hyperplasia—1) (cystic hyperplasia—1)
2) polypoid lesion—8	normal—2 (adenomatous hyperplasia—3) (cystic hyperplasia—1) (anovulatory endometrium—2)
3) submucous myoma—2	normal—2
4) synechiae—1	normal—1

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Five-year Emergency Medical Services Training Update for January 1, 1972 - January 1, 1977 and Emergency Personnel Continuing Medical Education Update Effective July 1, 1977

J. K. SIMS, M.D., *and* WILLIAM W. L. DANG, M.D., *Honolulu*

The Emergency Medical Services Program of the Hawaii Medical Association has been training emergency medical care personnel since January 1, 1972. With the turn of the 5-year training period on January 1, 1977, the HMA's EMS Program decided to evaluate its progress. The progress in training, as made available by the HMA-EMS Program, is summarized in Table 1, compiled February 7, 1977. Even more training progress has been made since January 1, 1977, and followup reports will be made to reflect changes in each category. Extensive training gains have been made particularly for the public safety personnel, Emergency Medical Technicians (EMT's), Mobile Intensive Care Technicians (MICT's), nurse, and emergency physician training. As of July 1, 1977, there were 98 MICT's, an increase over the previous 85.

Accepted for publication August, 1977.

From the Emergency Medical Services Program of the Hawaii Medical Association, as supported by federal funds under the EMSS Act of 1973. Compiled by J. K. Sims, M.D., HMA-EMS Program.

Reprints: William W. L. Dang, M.D., Project Director, HMA-EMS Program, 1301 Punchbowl Street, Honolulu, Hawaii 96813

TABLE 1.—*Persons Trained In Hawaii Medical Association–Emergency Medical Services Program (HMA-EMSP) Training Programs From 1/1/72 - 1/1/77: State Totals, Oahu Totals, Neighbor Island Totals, Compiled February 7, 1977.*

A	B	C	D	E	# TRAINED FOR OAHU VERSUS NEIGHBOR ISLANDS (BREAKDOWN OF COLUMN D)			
HMA-EMSP TRAINING PROGRAM	COURSE LENGTH (IN HOURS)	DATE FIRST COURSE OFFERED	TOTAL # TRAINEES PASSING	TOTAL # TRAINEES & % FAIL, DROP OR INCOMPLETE	TOTAL # TRAINEES OAHU # PASS	%	TOTAL # TRAINEES NEIGHBOR ISLANDS # PASS	%
Lay Person Cardiopulmonary Resuscitation (CPR)[1]	12-16	Summer '75	5	0	5	100%	—	—
Lay First Responder Course[1]	40	Summer '75	1	0	1	100%	—	—
Police First Responder (F.R.)[2] CPR	12	4/75	253 (24% of total	0	253	100%	—	—[10]
First Responder	14-24		253 to be trained)	0	253	100%	—	—
Firefighter First Responder[3] CPR	12	12/74	709 (79% of total)	0	709	100%	—	—[10]
40 hr. First Responder	40		187 (18% of total)	0	187	100%	—	—
Lifeguard (Ocean) First Responder[3] BLS CPR	12	11/74	63 (100% of total)	0	63	100%	—	—[10]
40 hr. First Responder	40		63 (100% of total)	0	63	100%	—	—
Emergency Medical Technician-Ambulance (EMT-A)[4]	400	11/71	287	22 (7%) (8 repeated)	208	72%	79	27%
Mobile Intensive Care Technician Assistant[5]	320	7/76	9	5 (36%)	9	100%	—	—[10]
Mobile Intensive Care Technician (Paramedic)[5,6]	1215	9/72	85	50 (37%) (10 repeated)	60[6]	74%[6]	21[6]	25%[6]
Emergency Room Registered Nurse[7]	120	4/73	160	0	148	92.5%	12	7.5%[11]
Intensive Care Unit Registered Nurse[7]	120	9/75	70	0	70	100%	—	—[10]
Emergency Room Physician (Variable)[8]	variable	7/73	N.A.	N.A.	average 34 (91%) Total Oahu Attending Cumulative - 495		average 2.5 (9%) Total N.I. Attending Cumulative - 35	

Hawaii Resident Population (excluding military, 1975)[9] Total *864,900;* Oahu *704,500* = 82%; N.I. *160,400* = 78%
All figures and percentages compiled from HMA-EMSP Training Staff Statistics (excepting the Hawaii Resident Population Figures)

Foot Note:
[1]not a formal training program of HMA-EMSP for any grant period
[2]training was variable, depending on time made available by the Honolulu Police Department (HPD); CPR is included (12 hrs. of Basic Life Support, CPR); Crash Injury Management Guidelines are used partially; HPD = 1050 field police (1490 total includes administrative personnel)
[3]program approved by OSHA State of Hawaii; includes American Heart Association BLS.CPR 1-2-3-4 Certification; Lifeguard Service (94 total, 88 field with *63* full time); Honolulu Fire Department (944 total personnel with 898 field)
[4]approved by *National Registry of Emergency Medical Technicians;* training described: *Hawaii Medical Journal* 35:227-232, 1976
[5]approved, Board of Medical Examiners, State of Hawaii
[6]excludes (MICT's as policemen (1), administrators (1), or full-time teachers (2) for island computations (N = 81 for island computations, not 85)
[7]approved, Hawaii Nurses Association
[8]excepting Hawaii Emergency Physician Seminars (HEPS) 1, 2, and 3, all remaining activities approved for Category I Pbysician CME Credits from A.M.A. and A.C.E.P.; 7 HEP Seminars, 2 Basic Life Support CPR Certification Courses, 1 Advanced Cardiac Life Support Certification Course; 7 HEPS (495 Oahu M.D. visits, 35 N.I. M.D. visits), CPR (8 M.D.'s—average attendance), ACLS (10 M.D.'s—average attendance)
[9]from Department of Planning and Economic Development: *The Population of Hawaii 1958-2025,* Statistical Report #114, Table A-2 (Total Resident Population) p. 10, State of Hawaii
[10]not offered by HMA-EMSP to N.I. personnel since grants were restricted to Oahu
[11]seven (7) of these Neighbor Island R.N.'s were trained to be instructors for tbe ER R.N. Course for each Neighbor Island

Once the baseline level of training is provided, there remains a need for continuing education on an annual basis. An outline for this continuing medical education according to the baseline training level of the emergency medical person has been summarized as compiled from the responsible respective agencies as of July 1, 1977. For example, an emergency physician in Hawaii who belongs to both the American College of Emergency Physicians (ACEP) and the Hawaii Medical Association would need to meet both the ACEP and the American Medical Association (AMA) continuing medical education (CME) requirements. The continuing medical education requirements for police persons are being developed since the baseline training is still being offered.

This 5-year progress report and the summarized continuing medical education recommendations are provided so that HMA members may witness the continuing progress of its project, the emergency medical services program. Updates will be provided periodically through this JOURNAL.

TABLE 2.—*Continuing Education Requirements/Recommendations In Hawaii For Emergency Medical Personnel, Compiled by the HMA-EMS Program, July 1, 1977.*

EMERGENCY HEALTH PERSONNEL	ACCREDITOR REQ./REC.	# HOURS
Emergency Physicians	American College of Emergency Physicians (ACEP/HACEP) AMA (HMA); *et al*	150 hrs/3 yrs. (av. 50/yr)
Registered Nurses (ER, ICU, CCU, etc.)	HNA	30/year (CEARP)
Mobile Intensive Care Technicians (MICT)	HMA-EMSP	32/year*
MICT Assistants	Courses in continuing education for EMT's	40 points*
	National Registry of Emergency Medical Technicians	60 points/2 yrs.*
Emergency Medical Technician (EMT)	National Registry of Emergency Medical Technicians	60 points/2 yrs.*
	HMA-EMS Program	21 hrs/yr.*
	SDOH Provisional	40 hrs/yr.*
Police First Responder	HMA-EMS Program	18 hrs/yr.*
Firefighter First Responder	HMA-EMS Program	18 hrs/yr.*
Lifeguard First Responder	HMA-EMS Program	18 hrs/yr.*

*Basic Cardiac Life Support (BCLS) Cardiopulmonary Resuscitation (CPR) 1-2-3-4 minimum annual recertification is required by the HMA-EMS Program and the American Heart Association as well as the Hawaii Heart Association and the Pacific Division of the American National Red Cross.

Abbreviations

ACEP = American College of Emergency Physicians
AHA = American Heart Association
AMA = American Medical Association
HACEP = ACEP, Hawaii Chapter
HHA = Hawaii Heart Association
HMA = Hawaii Medical Association
HNA = Hawaii Nurses Association
N.A. = Not Available
Nat Regis EMT = National Registry of Emergency Medical Technicians
SDOH = State of Hawaii Department of Health
CEARP = Continuing Education Annual Review Program

Under-Reporting of Birth Defects in Hawaii: A Pilot Study

SHARON J. BINTLIFF, M.D.,* *and*
DORETHEA B. HERNANDEZ, M.P.H.,** *Honolulu*

• *With the exception of epidemiologists, a few parents, and adults interested in validating their age, few persons care whether information on the birth certificate is complete or accurate. The subject of "under-reported" data on birth certificates has received little attention. A few studies have focused on the reporting of birth defects. However, most studies were limited to either a selected number of malformations, or hospitals with few births.*

*Associate Professor of Pediatrics and Genetics, John A. Burns School of Medicine.
**Student, Community Health Development Department, University of Hawaii School of Public Health.
Accepted for publication December, 1977.

In 1970, Hay *et al* compared reports of all birth defects noted on hospital records with the birth certificates of infants born during a one-year period in the State of Iowa.[1] Subsequent papers, expanding their data and their analysis and interpretation, indicated one startling fact: only 22% of all defects noted in the infants delivered in 141 Iowa hospitals were recorded on the birth certificate.[2,3]

In an attempt to evaluate and (hopefully) correct deficiencies in Hawaii's own reporting system, this pilot study was undertaken. The purpose was to assess the completeness and accuracy

of the reporting of birth defects on certificates of live births, using the largest maternity service in the State. The hypothesis was that reporting from a teaching institution, with active involvement of pediatricians, should be better than from smaller hospitals without pediatric surveillance. Also, if under-reporting is significantly high in such a hospital, then a thorough study of all hospitals in Hawaii is needed.

Rationale

An inexpensive, reliable, efficient birth defects registry is needed in Hawaii to serve the following purposes:

1. Early identification of infants and families to bring immediate treatment, planning and appropriate referral to community resources.
2. Planning and evaluation of inpatient and outpatient medical facilities and other programs to care for affected infants and their families.
3. Rapid detection of an unusual increase or decrease in frequency in time or place of certain birth defects.
4. Epidemiologic research into etiology of certain birth defects.
5. Planning and evaluation of programs for prevention of birth defects.
6. Evaluation of training needs of parents, professionals and caretakers for infants and children with birth defects.

Although only 30-50% of major anomalies are recognized within the 2-3 days of neonatal confinement,[4,5] accurate reporting of these, and subsequent reporting to Crippled Children Services Branch of the State Department of Health, by community physicians and specialty programs, is the most effective means of providing comprehensive planning and care for these children and their families.

Methodology

All live-birth hospital records were examined for a 12-month period (January 1 to December 31, 1975) in the private maternity hospital in Honolulu in which occur approximately a third of all live births in the State. Hospital records of these infants and their registered birth certificates relative to birth defects were abstracted and compared. The term, "birth defects," is used to mean those observable congenital anomalies noted and recorded any time from birth to discharge from hospital. Birth injuries were excluded.

The total number of live births in this period was 5,095, although records of only 5,038 were examined. The year, 1975, was selected because the comparative records from the Department of Health were readily available, whereas the 1976 data were incomplete.

Information abstracted from the medical records of the infants with birth defects included: 1) coded I.D.; 2) date of birth; 3) sex; 4) age of mother; 5) ethnic background of mother; 6) occupation of person responsible for financial obligations of patient; and 7) birth defect recorded. Recorded birth defects were abstracted from the "infant sheet for physicians," the nursery chart of the infant, or a separately prepared discharge summary. Data abstracted from the medical records of normal infants were: 1) age of mother; 2) ethnic background of mother; 3) occupation of person responsible for financial obligation of patient. These data were included to determine if the purposive sample was fairly representative of the women of child-bearing age in Hawaii. Identification of the study group was coded in such a manner as to maintain anonymity.

Birth defects data were classified into major and minor defects, using the classification of Myrianthopoulos and Chung.[6] The data were then coded, using the Eighth Revision of the International Classification of Diseases, Volume I, adapted for use in the United States. This is the code used by Research and Statistics Office, Department of Health, Hawaii, in coding birth defects recorded on birth certificates. Computer printouts were obtained from the Research and Statistics Office on all Certificates of Live Births (CLB) for the year 1975 from the sample hospital. These data were then compared with the hospital medical record data.

Analysis and Report

Comparing the purposive sample with normals for the same year, the sample was representative of women of child-bearing age in Hawaii. On review of the records, 147 infants were found to have 168 birth defects. Of these infants, 95 had 114 major defects (Table 1) and 52 had 54 minor defects. Using the number of records (5,038) examined as a denominator, the rates in Figure 1 were computed. From the Certificates of Live Births registered at the Department of Health, 40 infants were recorded as having 43 birth defects. Of these infants, 34 had 37 major defects and 6 had 6 minor defects. Using the number of Certificates of Live Births recorded (5,095) as a denominator, the rates in Figure 1 were compiled. From these figures it can be seen that, for this sample from hospital records, 2.89% of the study infants had birth defects. Computing from the Certificate of Live Births, however, the incidence of birth defects for the year 1975 would be only 0.789%. Of birth defects occurring at this hospital, 25.6% were recorded on the registered Certificate of Live Birth; 74.6% were not recorded.

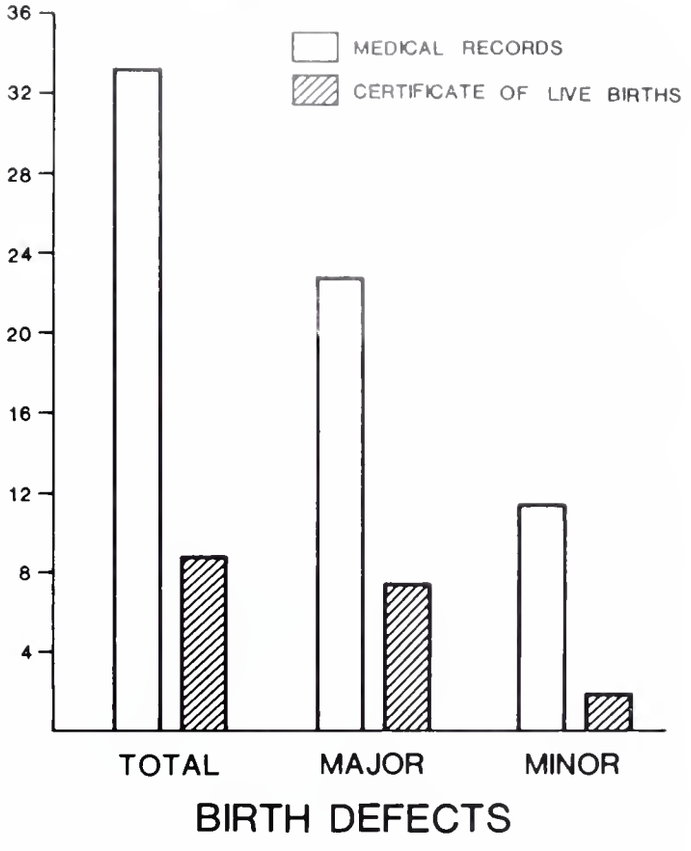
Discussion

In reviewing the hospital procedures as outlined in Table 2, one fact was obvious: the birth certificate is filled out by persons not directly involved in the infant's care. The primary physician for the mother, whether obstetrician or gen-

TABLE 1.—*Major Anomalies.*

TYPE	NUMBER	ACTUAL RATE PER 10,000 LIVE BIRTHS
Central Nervous System	7	14
Myelomingocele/Spine Defect	5	10
Pulmonary	5	10
Cardiovascular		
Murmur (Unspecified)	11	22
Congenital Heart Disease	13	26
Eye	2	4
Cleft Lip and Palate	4	8
Cleft Lip	1	2
Cleft Palate	6	12
Ears (Microtia)	2	4
Gastrointestinal	10	20
Genitourinary	10	20
Extremities		
Upper	2	4
Lower	9	18
Both	1	2
Hips	7	14
Syndromes		
Chromosomal	3	6
Arthrogryposis	2	4
Adrenogenital	1	2
Achondroplasia	1	2
Multiple Congenital Anomalies (2 or more major anomalies but not recognized as syndrome)	7	14

FIG. 1.—*Rates per thousand live births.*



eral practitioner, rarely has access to the infant's record at the time the birth certificate is completed. Therefore, it is not surprising that in the hospital surveyed, 74.6% of birth defects went unreported. One solution to this major problem of under-reporting would be to have the pediatrician or physician responsible for the infant's care complete these records and co-sign with the physician caring for the mother.

In cases where the baby requires transfer to another center for specialized care or diagnostic procedures, the certificate could be held until the diagnosis is made (rarely more than 2-3 days).

Adequate health and educational planning for infants and children with birth defects and lasting handicaps will always depend upon anticipated needs. This study suggests that we should quadruple what we think we need in order to have adequate services. That seems neither a desirable nor a scientific way to plan. The problem of adequate reporting of those birth defects which appear after infants are discharged from the nursery will be solved only with the utmost cooperation between Crippled Children Services Branch of the State Department of Health and the entire medical community.

TABLE 2.—*Routing Of Birth Certificate In Hospital.*

PRE-ADMISSION FORM PRENATAL VISIT
FORM FILLED OUT & MAILED TO HOSPITAL
CERTIFICATE OF LIVE BIRTH ACTIVATED & HELD UNTIL ADMISSION
ON ADMISSION-MEDICAL RECORDS NOTIFIED MOTHER IN FOR DELIVERY
DELIVERY ROOM NOTIFIES PBX WITH VITAL STATISTICS ABOUT INFANT INFORMATION SENT TO MEDICAL RECORDS
MEDICAL RECORDS COMPLETES CERTIFICATE OF LIVE BIRTH & TAKES TO MOTHER TO VERIFY
MASTER CERTIFICATE OF LIVE BIRTH TYPED & SIGNED BY MOTHER
CERTIFICATE OF LIVE BIRTH PLACED ON FLOOR TO BE COMPLETED BY MOTHER'S PHYSICIAN
MEDICAL RECORDS PICKS UP CERTIFICATE OF LIVE BIRTH FINALIZES DOCUMENT & MAILS TO DEPARTMENT OF HEALTH

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JON WON

HMA Continues its participation in the *voluntary effort committee* which hopefully will provide impetus to voluntary approaches by providers of health care to reducing the spiral in the rise of health care costs. Physician input on behalf of HMA is appreciated especially in light of the meeting times of this *voluntary effort committee* which seem to occur during normal office hours. The voluntary effort, originally viewed by some with skepticism and by the FTC as "antitrust," seems to be catching on in the medical community.

The 9% Solution conference held recently on Molokai produced some very open and frank discussion between those individuals and agencies involved in the health care field, as well as legislators and consumers who have an interest in the concerns of health care delivery and cost. This conference produced a framework for followup of the ideas presented and discussed at the conference and further activities should be occurring very soon.

The Honolulu County Medical Society has completed its purchase of the Physicians Exchange. It will become, as of July 1, 1978, a wholly-owned subsidiary of the HCMS with expectations of providing a much-needed service to physicians as well as developing other services for physicians.

The AMA Was Granted a temporary restraining order blocking the release by HEW of the list of physicians who received Medicare payments in 1977. The AMA suit, filed against HEW Secretary Joseph Califano, noted that Califano said he would publish the list as soon as it is developed "in callous disregard of the reasoning of federal district courts in Florida and Louisiana," which have already issued restraining orders pertaining to physicians in those states.

AMA's 127th Annual Meeting, the last one to combine a meeting of the House of Delegates and a Scientific Program, was held June 17-22 in St. Louis. This House of Delegates was one of the busiest in history with well over 200 reports and resolutions considered. In addition, the Board of Trustees report on the Report on the National Commission on the Cost of Medical Care required some 50 actions by the House. Representing HMA at the Annual Meeting were President Marion Hanlon, President-elect George Goto, Delegate Herbert Chinn, Continuing Medical Education Chairperson Nadine Bruce, and Executive Director Jon Won. Mrs. Berna Yim, president of the HMA Auxiliary, was also present for the Auxiliary portion of the meeting.

Records Kept By PSROs are public documents that may be obtained under the Freedom of Information Act, a federal judge in Washington, D. C., ruled. In a lawsuit brought against a Washinton PSRO by Ralph Nader's Public Citizen Health Research Group, which sued to obtain the PSRO's records. The U. S. District judge maintained that the crucial role played by that PSRO in the public health process makes it a public agency subject to disclosure of public records. It is expected that this decision will be appealed. Recent information of Congress hurrying to enact legislation to exempt PSROs from the Freedom of Information Act is not really so—Congress is only considering such legislation.

It Has Come To The Attention Of The HMA Office that Argonaut Insurance Company, a major carrier for professional liability insurance in Hawaii, will not be requesting any increases in its premium rates, even for inflationary trends! It is also understood that the current issuance of three-month policies will also be modified in the very near future to the issuance of six-month policies. This news is most welcome because it is some indication of the stabilization of the situation with regard to professional liability insurance and, perhaps, the litagation involved. Let's keep our fingers crossed!

St. Francis Hospital Neighborhood Health Center now recruiting for a Family Practitioner, board certified or eligible internist or family physician. Outstanding opportunity to provide innovative health services with emphasis on preventive care. Interested physicians send *curriculum vitae* to Paulina Murray-Lee, Director,

Neighborhood Health Center, St. Francis Hospital, 2230 Liliha St., Honolulu, Hawaii 96817.

Primary Care Center, hospital-based group practice, recruiting board certified/eligible family practitioner. Contact Robert S. Sitkin, M. D., Medical Director, Primary Care Center, St. Francis Hospital, 2230 Liliha St., Honolulu, Hawaii 96817.

Wanted: Assistant Professor of Medicine, Full-time, federal funds, one year, annually renewable, pending receipt of funds. To provide specialty knowledge and training, post-graduate and continuing medical education in the Dr. Torres Hospital, Saipan, Mariana Islands; supervise and monitor fourth year medical students assigned to the hospital in a preceptorship; advise the Director of Health Services of the Northern Mariana Islands in the area of adult medicine. Minimum qualifications: board eligible and medical licensure in one of the 50 states; teaching experience. Desirable to have board certification in Internal Medicine and experience in cross-cultural setting. Apply to: Irwin J. Shatz, M.D., Chairman, Dept of Medicine, Univ. of Hawaii School of Medicine, 1356 Lusitana St., Honolulu, Hawaii 96813. Closing date July 30, 1978. An equal opportunity employer.

Also Wanted: Assistant Professor of Surgery, full-time, federal funds. One year, annually renewable pending receipt of funds. To provide specialty knowledge and training, postgraduate and continuing medical education in the Dr. Torres Hospital, Saipan, Mariana Islands; advise the Director of Health Services of the Northern Mariana Islands in the area of general surgery. Minimum qualifications of board eligibility and medical licensure in one of the 50 states; teaching experience. Desirable to have board certification in general surgery and experience in cross-cultural setting. Send resume to Thomas Whelan, M. D., Chairman, Dept. of Surgery, Univ. of Hawaii School of Medicine, 1356 Lusitana St., Honolulu, Hawaii 96813. Closing date July 30, 1978.

Michigan Academy of Family Physicians announces its 32nd Annual Postgraduate Clinic, July 30 - August 3, 1978, at Sugar Loaf Resort, Cedar, Michigan. Format: Medical Problems of the "WORLD'S SICKEST FAMILY." Up to 30 hours Category I and AAFP Credit available. Contact Mrs. Rita Feldkamp, Executive Secretary, 933 Wing St., Plymouth, Michigan 48170.

Beth Israel Hospital announces its 1979 Winter Conference Schedule. During February and March, 1979, conferences have been scheduled in family practice, urology, Ob-gyn, psychiatry, emergency medicine/critical care, radiology, cancer, general surgery, gerontology, internal medicine, and pediatrics. Most conferences are held in Vail, Colorado; one is held at Aspen. All of the conferences have been approved for AMA Category I credit (22 hours for all except Radiology which is 25 credits). Copies of schedule available at HMA office.



Why We Can't Afford National Health Insurance

Saturday Review recently published an article by Robert Clairborne, adapted from his forthcoming book "The High Cost of Health—And What to Do About It," which addressed certain trade-offs that need be made to effectively control health care costs. The article states in part:

If consumers—who ultimately pay for the health care system—must accept trade-offs if they hope to pay less, then the third parties who hand out money have got to make trade-offs of their own: specifically, to quit subsidizing wasteful providers. This means not just Blue Cross-Blue Shield and the commercial insurance companies but also the federal government's Medicare-Medicaid. All of these have tended to reimburse providers for whatever they spend, wasteful or not. Moreover, the Medicare-Medicaid reimbursement formulas, thanks to conservative pressure and bureaucratic foot dragging, have made it difficult and sometimes impossible for cost-efficient providers to accept patients under these plans.

Over the longer run, curbing health costs means cleaning up the environment, since pollution is not merely unattractive but usually unhealthy as well. A concerted effort to abolish this source of disease would be expensive—but probably cheaper than a policy of letting diseases develop and then spending billions of dollars to

treat them. (It is worth recalling that the single most effective health program in history involved not treatment but prevention: providing the sanitary water and sewage systems that ended such plagues as typhoid and cholera.) Another kind of prevention would involve changing personal life-styles, which obviously can affect health (through overeating, overdrinking, and smoking). Yet another would involve the problem of poverty, which throughout history has been—and remains—a fertile source of disease.

Central to any of these measures, however, are two changes in human thinking. The first is for all Americans to recognize that whoever ostensibly pays for health care, *we* have to foot the bill—through higher prices, higher insurance premiums, and higher taxes. No less important is the recognition by both doctors and patients that bigger isn't necessarily better and may well be worse. Measured by its plant and equipment, the American health care system is the most technologically profligate in the world. Measured by its hospital admissions, surgical operations, and laboratory tests, it is probably the busiest in the world—and it is unquestionably the costliest in the world.

We've simply got to hold back!

In the last issue of the HMJ (May 1978 Vol. 37 No. 5) the problem of cost control in medical care was repeatedly mentioned: In the lead editorial, and in several places in *News & Notes* under Hors de Combat. The ordering of unnecessary X-rays was mentioned in particular.

The reader may be thoroughly tired of the subject, but the problem won't go away. We in the profession **must** face up to it, and, what's more, do something about it. It has become increasingly obvious that it is the physician who holds the reins of this wild runaway. The continuing references in the Press, the threats of government intervention and the efforts of consumerism all have borne down on the role of the medical profession.

Let us look at just one small aspect of the problem, that of the unnecessary X-ray.

A strong, young, physically fit man becomes inebriated and happens to injure himself in an accidental fall. He has momentary loss of consciousness, they say, but his inebriation makes that difficult to evaluate, medically speaking. Panicky people cause him to be rushed to the hospital emergency room (once put on modern medicine's conveyor belt, it is next to impossible for the patient to get off, or to be put off!). The patient is alternately belligerent, morose, maniacal and totally uncooperative. He has multiple external injuries; the index of suspicion for internal injuries is high.

He could have been sent home, after a simple physical examination that revealed vital signs to be normal and stable, to be observed by his family, who could have been alerted to symptoms and signs of serious portent. If all went well and he slept off his "drunk," a further medical evaluation could have been postponed to the time when reason and cooperation would prevail. He certainly was not a good candidate for a hospital admission for observation, he being so noisily maniacal and unmanageable at the time.

The dilemma, then, was one of weighing the risk of release from medical supervision.

An important factor contributing to the dilemma was the not insignificant one of liability. Once in the hospital ER door, the patient becomes the responsibility of the hospital and of the physician-in-charge, no matter how the patient reacts.

Different physicians would each have approached this case differently. It is easy to be a Monday morning quarterback. With a certain human sympathy for the man-on-the-spot: The examining physician, one can very well understand his dilemma.

It still came as a shock, however, the next morning (the patient *was* admitted overnight for other reasons), when the young man, recovered and remorseful, with a hangover and sore in many places of his body but with a clear sensorium, walked past the discharge counter and got his hospital bill. He had been X-rayed from head to foot, literally, and only one small metacarpal fracture found on the positive side. The bill for the 15 to 20 views? $174.00! And, an

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extra $9.00 was added to make the total $183.00, thrown in because all these were taken "after regular hours." The radiologist's bill would come later.

The exigencies of the moment and the fear of liability on the part of the examining physician are understandable. But, there might also have been an element of his being afraid to miss something serious, which translates perhaps into inexperience. The modern young physician has not been trained to "wait and see; it may be better in the morning." He has been trained to cover all bases stat!

Surely, the answer must lie in awareness—awareness of costs, awareness of cost/benefit ratios. The physicians on the medical staffs of hospitals need to be educated in this; emergency room physicians, in particular, need such an awareness.

Hospitals gain from overutilization and there is no incentive for the institution to promote this awareness of cost/benefit ratios. However, rather than do nothing in the face of imminent across-the-board cost controls imposed by law, these institutions might wisely choose to cooperate with, and assist medical staff physicians in becoming cost conscious.

One inexpensive way to do this would be for hospital accounting offices to send the physician a copy, itemized in detail, of the patient's out- and inpatient bill.

JIFR





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INTERNAL MEDICINE



Norman Nakashima, M.D.

888 South King Street
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GENERAL PRACTICE



Theresia Giok Hwa Tan, M.D.

94-235 Leoku Street
Waipahu, Hawaii 96797

PEDIATRICS



April 7, 1978, 5:30 p.m.
HMA Conference Room

PRESENT

Drs. Marion Hanlon, George Goto, Douglas Bell II, William Hindle, Herbert Chinn, William Iaconetti, George Mills, Patrick Walsh, Russell Stodd, Rex Couch, Neal Winn, Rowlin Lichter, Leonard Howard, Alexander Roth, Felix Lafferty, Denis Fu, Peter Kim, Arnold Siemsen, Arch Wigle, Donald Char, and Ann Catts plus Mrs. Dorothy Shepard, Drs. Nadine Bruce and Grover Batten, Mr. V. Thomas Rice.

EXCUSED

Drs. Calvin Kam, James Williams, and Calvin Sia.

MINUTES

The minutes of the March 3, 1978 meeting were approved as circulated.

REPORT OF THE SECRETARY

Mr. Won reported that there were 822 members of the HMA as of April 1, 1977 and that there were 114 members with dues outstanding. The county society presidents were reminded that dues should be submitted by April 30th.

ACTION:

It was voted to accept the report of the secretary.

REPORT OF THE TREASURER

The financial statement for the month of February 1978 was reviewed by Mr. Won. It was noted that a full report will be presented at the next Council meeting.

ACTION:

It was voted to accept the February 1978 financial statement subject to audit.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. Mabel Smyth Board: Dr. Batten reported that the Mabel Smyth Board has signed the bill of sale for the Nurses and Physician's Exchange which will be purchased by the Honolulu County Medical Society. The tri-partite agreement between Queen's Medical Center, Hawaii Nurses Association, and the HMA is being reviewed by Queen's and should be dissolved by the next Council meeting.

B. Legislation: Dr. Howard reported that it appeared the State Legislature would enact legislation to provide for a permanent statewide School Health Program, funding for the EMS program, and a definition of death. There was discussion regarding the decision to request postponement of legislation which would have established a commission on medical, moral, and legal concerns. It was noted that while the HMA House of Delegates had endorsed this concept there was objection by some HMA members to the concept of placing the commission outside the HMA and it was felt that further discussion was needed prior to the enactment of legislation.

C. Health Services and Care: Dr. Char reported that the Community Health Committee had reviewed the proposed State Health Plan in depth and that he had met with the HMA Executive Committee to discuss the HMA position at the public hearings called by SHPDA. Copies of the position were sent to all HMA Council members. Dr. Char reported that the Statewide Health Coordinating Council would review the comments made in public hearings and would have final approval of the plan to be submitted to the Federal government.

Dr. Hanlon reported that SHPDA has asked HMA to sign a memorandum of understanding for exchange of information and data and this will be reviewed by the Community Health Committee for recommendation at the next Council meeting.

D. Cancer Center: Dr. Bell reported that Dr. Diane Fink from the National Cancer Institute had visited the HMA as well as the Cancer Center Community Cancer Control Program and had noted some of the concerns regarding the future of the CCCP. She expressed concern that there was apparently little physician input into the programs and hoped that this situation will change in the coming months. Dr. Hanlon reported that he has not received a reply to the letter written in February to the University of Hawaii requesting clarification of the issues regarding the executive board of the Cancer Center of Hawaii. He noted that the Cancer Society had also written to the University regarding their concerns.

ACTION:

It was moved and seconded that a letter be sent to the University asking for a comprehensive response to the issues and apparent abrogation of agreements reached between the University and the Hawaii Medical Association regarding the Cancer Center of Hawaii (CCH) and noting that unless a response is received within one week from the date of the letter the HMA will withdraw its support and participation in the CCH. The motion was passed.

E. Internal Affairs: Dr. Bell reported that the HMA Annual Meeting will be held October 1-6, 1978 at the Ilikai Hotel. He reported that the Convention Committee is presently looking at possible sites and dates for the 1979 meeting and should have a recommendation at the next Council meeting.

F. Hawaii Tumor Registry Board: It was reported that the officers of the Board for the Hawaii Tumor Registry are Dr. Douglas Bell, President; Dr. Paul Condit, Vice President; Dr. Calvin C.J. Sia, Secretary; and Dr. William Hindle, Treasurer. The HTR Board met with Dr. Max Meyer of the NCI during a recent visit and discussed possible sources of funding for the registry.

G. Public Affairs: Miss Barbara Chapman, Associate Director of Public Relations of the American Medical Association visited Honolulu in March to meet with HMA and HCMS committees as well as representatives of the news media and to observe and assess ways in which the AMA might assist the Association. A copy of her entire report was disributed which has several recommendations for followup action.

ACTION:

It was voted to support the establishment of a public relations specialist and to accept the offer of the Honolulu County Medical Society to share in the expense of hiring this individual, and that the executive director develop a job description and actively seek to fill the position. It was also

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noted that this position will be a continuous one but that the House of Delegates is expected to evaluate the public relations program. It was also voted to notify the public relations agencies who had indicated some interest in developing a program for the HMA that the Council has approved the concept of adding a specialist to the HMA staff.

H. EMS: Dr. Dang reported that the Conference Committee on EMS Legislation from the Senate and the House had agreed to include $687,000 in the State budget for the EMS program. He noted that the program received a lot of help from Kazuhisa Abe, HMA's Legislative Counsel, in preparing for the hearings on this legislation.

I. Building Committee: Negotiations regarding the extension of leases in the 320 Ward Building were reviewed by the Building Committee. It was requested that the Council allow the committee to spend an additional sum of $125 to complete the reappraisal of the building.

J. Cost Containment: Dr. Hanlon reported that the National Commission Report on Cost Containment had been distributed to members of the Council. He announced that the Hospital Association has formed a Cost Containment Committee chaired by Mr. Duane Black which has three representatives from the HMA, representatives from each of the major hospitals as well as from HMSA and the community. He also reported that plans for the 9% Solution Conference to be held on Molokai and which HMA has contributed to are progressing. Dr. Mills reviewed the progress on the Cost Containment report and noted that the Board of Trustees of the AMA will be reviewing the report and that any comments from the HMA would be welcomed. The AMA House of Delegates will consider the Cost Containment report at the June meeting.

K. Bureau of Research and Planning: The Bureau has discussed the feasibility of developing a Diabetes Registry as well as the development of an HMO. These projects will be explored further.

L. Medical Education: Dr. Bruce reminded the Council that the House of Delegates has set January 1, 1979 as the starting date for requiring evidence of CME for membership. The State Board of Medical Examiners has indicated it will probably require evidence of CME for relicensure as of January 1, 1980. The HMA CME Committee recommends that the Council not drop members who do not meet the January 1979 deadline but to use that year as a grace period to iron out some of the problems some physicians will face in meeting these requirements. The Committee also requests Council approval to draft a proposal to be submitted to the Board of Medical Examiners for a CME Record and Information System.

ACTION:

The Council voted to approve the recommendations of the Committee.

M. HMA Auxiliary: Mrs. Shepard announced that her term as president would be completed in early May and that Mrs. Berna Yim, president-elect, would attend future meetings of the Council. She noted that the Auxiliary is in the process of hiring a part-time secretary to do some of the Auxiliary work. Mrs. Shepard was asked to present the AMA-ERF check to the UH Medical School by May 20th

N. Report of the County Medical Societies: Dr. Couch reported that the members of the Kauai County Medical Society have been working on the State Health Plan and have met with the subarea council on Kauai. There were no reports from Hawaii, Honolulu, or Maui County Societies.

NEW BUSINESS

A. Reference Library: Mr. Won requested permission to purchase shelving for the development of a reference library for the HMA, PSRO, HCMS. It is expected that HMA will be reimbursed for part of the expense. Council approved the expense of $550.

B. It was announced that the deadline for AMA Resolutions is May 19th.

C. Letter from Utah Medical Association: A copy of the letter regarding the methods used to investigate Medicaid fraud and abuse in Utah will be sent to all Council members for information and discussion at the next meeting.

D. House of Delegates: Dr. Mills requested that HMA look into the feasibility of including a seat in the House of Delegates for interns and residents.

E. AAMSE: Mr. Won reported that AAMSE has requested a contribution from county and state medical associations which would be used for training future medical society executives. It was voted to contribute $100.

F. Dr. Winn asked that the Council consider initiating legislation which would permit the use of funds received from the 4% tax on medical expense and drugs to be released for medical education and peer review activities. He noted that many physicians spend



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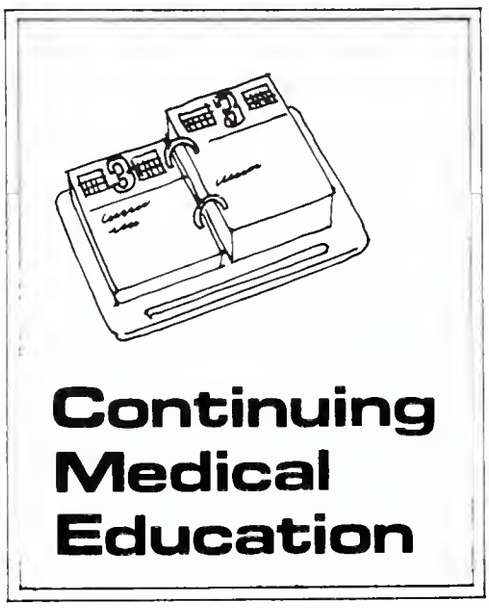
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at least 25% of their time on committees necessitated by government, peer review, third party review, etc., which forces some into maldistribution of income. This will be explored further.

ADJOURNMENT

The meeting adjourned at 9:25 p.m.

DOUGLAS B. BELL II, M.D.
Secretary



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/ Maui Mem. Hsp.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Fridays, 8:00-9:30 a.m., Room 618, University Tower, Queen's. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
3. U.H. Cardiology Grnd. Rnds., 1st Tues. 5:30 p.m. Rm. 506 Univ. Tower, Queen's.
4. UH Grand Rnds-Ob/Gyn, Wed. 7:30-8:30 a.m. Kapiolani Hsp. Aud.
5. UH Perinatal Conf., Thurs. 3:30-4:30 p.m. Kapiolani Hsp. Rm. 815.
6. UH Seminar, 2:30-3:30 p.m. Kapiolani Hsp. Rm. 826. Fridays, 1st-Pathology; 2nd-Perinatology; 4th-Journal Club.
7. UH Conf., Friday, 3:30-4:40 p.m. Kapiolani Rm. 826.
8. UH Visiting Prof. Program for Ob-Gyn, Quarterly.

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.

(Contact CME Dept.-Kaiser for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Kapiolani Maternity Hospital

1. Tuesday Conference, 1:00-2:00 p.m. Kapiolani Hsp. Aud.
 1st—Didactic Presentation
 2nd—Perinatal-Neonatal Topics
 3rd—Obstetrics Topics
 4th—Gyn Topics
2. Neonatal Grand Rnds., Friday 8:00-9:00 a.m. Kapiolani Hsp. Nursery.
3. Tumor Board-Oncology Conf., 1st & 3rd Friday, 1:00-2:00 p.m. Kapiolani Hsp. Aud.

Kuakini Medical Center

1. Visiting Professor Programs
2. G.I. Conf., 3rd or 4th Tues, 8:00-9:00 a.m.
3. Ophthalmology Departmental Mtg., 2nd Tues. 1:00-2:00 p.m.
4. Medical Mortality & Morbidity Conf. (Dept. of Med. Mtg.) 4th Tues. ea. month, 1:00-2:00 p.m.
5. Nephrology Conf., 2nd & 4th Wed., 8:00-9:00 a.m.
6. Oncology Conf., ea. Thurs. 7:30-8:30 a.m.
7. Surgical Conf., 1st, 2nd, & 3rd Friday, 1:00-2:00 p.m.
8. Surgical Mortality & Morbidity Conf. (Dept. of Surg. Mtg.), 4th Friday, 1:00-2:00 p.m.)

(Contact CME Dept.-Kuakini for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room

3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
6. SFH-UH Surg. Sat. Teaching Rnds. (except 4th) 7:30-8:30 a.m. UH 4 Classroom.
7. SFH-UH Hematology Conf., 4th Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
8. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
9. Tumor Conf., ea. Monday, 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Cardiac Surgery Meeting meets the 2nd Tuesday of the month, from 4:30-5:30 p.m. in the Doctor's Dining Room.
3. Friday Noon Conference meets weekly, from 12:30-1:30 p.m., in the Doctor's Dining Room.
4. Medical Grand Rounds meets the 1st Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.
5. Orthopedic Conference meets quarterly, from 7:30-9:00 p.m., in the Doctor's Dining Room.
6. Quarterly Professional Meeting meets the 4th Monday of the month, from 7:30-8:30 p.m., in the Doctor's Dining Room.
7. Surgical Mortality and Morbidity meets the 4th Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu
Type: I, 1 hr./day, 1 day/mo. from 12 mos.
Fee: None Methods: AV, O, Pan
Dates: All yr., 12 hrs. instruction

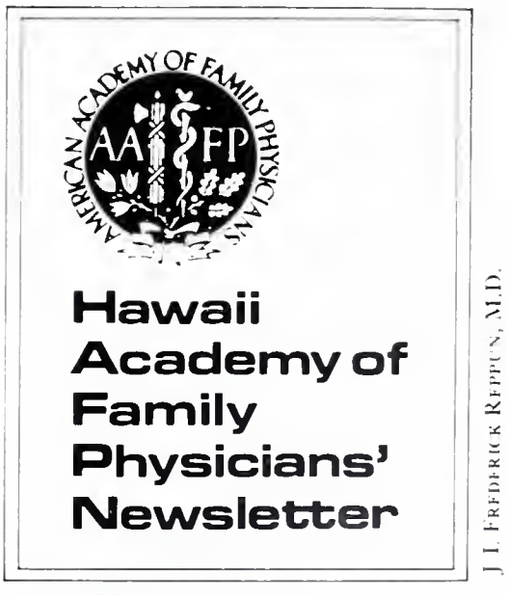
Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: I, 1 hr./day, 1 day/mo. for 8 mos.
Fee: None Methods: AV, Clin C, O, Pan, R
Dates: Arranged; 8 hrs. instruction

SPECIAL EVENTS

July 1-8, 1978	USC School of Medicine—Manipulative Medicine, Mauna Kea Beach Hotel, contact Peter Millati, Fitzpatrick Travel Service.
August 5-12, 1978	USC School of Medicine-Ophthalmology, Mauna Kea Beach Hotel, contact Peter Millati, Fitzpatrick Travel Service.
August 12-19, 1978	USC School of Medicine post graduate refresher course, Sheraton Waikiki, Peter Millati, Fitzpatrick Travel Service.
August 26-Sept. 4, 1978	Post Grad. Education for Professionals—U of C Schl. of Med. Held at Mauna Kea Beach Htl. Contact: Barry S. Ramer, M.D., Director, U of C Schl. of Med. Calif. 18 hrs. Cat. I.
Sept. 20-23, 1978	Genetics & the Pediatrician—What Every Ped. Should Know.—Held on Oahu & Maui. Contact: Wilma Schiner, Workshop Coord. Kapiolani-Childrn's Hsp. 1319 Punahou St., Honolulu, HI 96826 for further info.
Sept. 28-Oct. 7, 1978	Am. Acad. of Family Phys. 1978 Invitational Scientific Congress. Roger Tusken, Exec. Dir. 1740 West 92nd St., Kansas City, MO 64114. Held at Maui Surf Htl.
Oct. 1, 6, 1978	122nd HMA Annual Mtg. & AMA Regional CME Mtg. Ilikai Htl. Ala Moana Blvd., Honolulu. Contact: Mrs. Bess Chang at HMA for further info.
Oct. 2-6, 1978	Western Dialysis & Transplant Soc. Held at Hilton Hawaiian Village, Honolulu. 12 hrs. Cat. I. Contact: Arnold Siemsen, M.D., General Program Chairman, (808) 547-6522.
Oct. 8, 14, 1978	Am. College of OB/GYN. Held at Sheraton Waikiki/Kauai/Maui/Kona Surf. Cat. I. Contact: Wm. Hindle, M.D. 888 So. King St., Honolulu 96813, Ph. (808) 523-2311.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



New Members—None.

News of Members—Kiyoshi Inouye, an Active member for 19 years, has retired and has been voted a Life Member. **Douglas Doyle** in a letter-to-the-editor (*SB* 5/17/78), as a member of the Right-to-Life Group, wants the recent Con-Con election to be declared null and void because its membership is biased. **Dick Tesoro** of Mililani Town was honored by being elected one of 4 regional VP's of the alums of U of Oregon Med School. **Glenn Stahl** was on a WW Community College panel on "How to Make the Most of Stress" on 2 June. **Mike Hase,** our EduCom chairman, has been authorized by the Council to represent the Hawaii Chapter at a workshop in Kansas City on Credit Hours on 10 June. AAFP is in the throes of extricating itself from the confusion between AAFP "P" credit and the AMA's Category 1.

Members Dropped—Catalino Cachero, an Active member since 1970, elected not to comply with the requirements for continuing membership of the Academy.

At the **Dinner Meeting on 20 May** at **Fred Lam's**—there was an attendance of 42 total, including 9 medical students as guests of the HAFP. Howard Furumoto, DVM, gave an interesting talk on animal diseases that relate to man. Pres. **Tom Cahill** followed with a fascinating account of the business aspect of his 2-man office practice. Would that we could all be that precise and efficient!

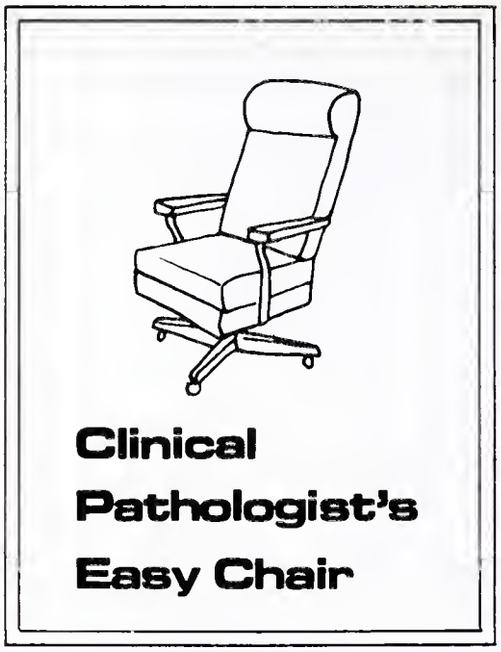
CME—is coming out our ears! Everyone is in on the act! Much of it is for considerable cost; some is for free—by the drug companies mostly. Remember USC-UH-Tripler PG Refresher Course 12 to 23 August. Lung Cancer Care on 23 June at the Ala Moana Hotel is AMA 1 but *not* AAFP "P"! Dan Hanley MD, advisor to the US Olympic Team, speaks at Tripler on 28 June on Sports Medicine (not listed as "P" credit). Core Content Review for 32 hours of "P" starts 1 Oct and goes for 8 months; registration deadline is 31 Aug. The Georgia AFP has several good things in prospect: Correspondence courses in Primary Care Geriatrics for 30 "P," and in Primary Care of the Newborn also for 30 "P"—registration deadlines for both are 10 July. Dialogues in Hypertension offers a self-assessment program good for 24 hours of "P" for the next two years starting this Fall, for free.

AAFP CME—The American Academy has come out with a brand new format for a Home Study Self-Assessment Program. Solicitations for Charter Enrollment have gone out to each member. The price for members is $190 and for non-members $250. This buys 12 monthly learning packages that include pretests, monographs and study guides, a 1-hour tape cassette, a post-test and finally an annual cumulative test to determine retention capabilities. There are others like this coming out and on the horizon, including freebies. This is the wave of the future; AMA's category 1, AAFP's Cat "P" and "E" will soon no longer meet the acceptable requirements of CME for licensure that is already upon us.

A New Bestseller—AFP/March 1978 cites Dr. Peter Lawrence as indicating that Valium is **the** most prescribed drug in the U.S.A., with Premarin, Ampicillin and Lasix following next in order.

Higher Pay for FP's—The National Academy of Sciences was reported in the *Star-Bulletin* (5/11/78) as recommending that FP's and other Primary Care physicians be reimbursed on an equal scale as the specialists for like work. This is aimed particularly at Federal and State government programs, but recommends also that third-party payers **not** discriminate against rural primary care physicians by "geographic differentials" in fees.

Cancer—The Cancer Control Program of the AAFP, to which many of us members subscribe as participants in cancer research demography, reports that cancer of the ovary, the leading cause of death in gyn malignancies, has a survival rate of only 25% among all women in the USA, for 5 years. The mortality rate has increased 250% since 1930. Neither has the survival rate changed in the last 30 years in colon/rectal cancer; the survival rate remains around 45% for all stages combined, but it is 75% in "localized" disease. The screening by Hemoccult or Guaiac is coming to be recognized as of great value and accuracy.



Liver Function Tests

Liver physiology is complex. Hepatic functions include elimination of metabolic wastes, detoxification of drugs and manufacture of essential compounds. Insult to the liver results in alteration of these various functions and consequent change in blood levels of various components. Liver function tests are used to determine the presence of hepatobiliary disease, to differentiate the types and to follow the course of the disease. However, they are not *always* capable of detecting liver disease nor can they *always* differentiate the possibilities. The correct diagnosis is not possible

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in some cases even with liver biopsies, scans and cholangiograms.

Hepatobiliary disease is categorized into parenchymal disorders and excretory function disorders. The parenchymal diseases include hepatitis, cirrhosis and tumors. Excretory system diseases may be due to calculi, neoplasm, strictures, drug-cholestasis, space-occupying lesions, cholangitis and cholestatic phase of parenchymal disease. Hyperbilirubinemia may be prehepatic due to excessive red blood cell destruction, posthepatic due to obstruction of the excretory system, or hepatic due to parenchymal disease. In mild cases, the total bilirubin may be within normal limits but the direct will be more than 0.3 mg/dl.

The transaminases, aspartate (GOT) and alanine (GPT), are the most widely used enzymes in the study of parenchymal disease. Both are elevated during the prodromal periods of hepatitis and are typically greater than 500 units. The levels are higher in icteric than anicteric patients. The SGPT is usually higher in the early stages of viral hepatitis, while the SGOT is higher in chronic hepatitis, cirrhosis, congestive hepatomegaly and with liver metastases. Transaminases tend to return to normal about the same time as the bilirubin. Coagulation factors are affected by liver disease, the most commonly tested being the prothrombin time. It is increased in both parenchymal and excretory disease, and no response to Vitamin K indicates a poor prognosis.

The most commonly used enzyme in excretory disorders is the alkaline phosphatase. This enzyme is produced in the liver excretory system, bones, intestines and placenta but the most important differentiation to make is between bone and biliary tract. Some people use the leucine aminopeptidase (LAP) and 5'Nucleotidase to make this differentiation, but the gamma glutamyl transpeptidase (GT or GGT) is a much more specific and sensitive test.

The GGT is produced by the entire hepatobiliary tract, as well as by the pancreatic acini and ductules. It is elevated in all types of liver disease, highest levels being found in both intra- and extra-hepatic obstruction. It is often elevated before the alkaline phosphatase and remains elevated longer. It is often increased with metastatic carcinoma and in chronic alcoholism despite normal GOT and alkaline phosphatase activities. It is not elevated in bone disease, but may be increased with vascular brain tumors and epilepsy. Certain drugs such as barbiturates and dilantin may also cause increased levels of activity.

The BSP test is used primarily for liver disease without jaundice. The serum level may also be increased in other conditions such as congestive heart failure because of decreased blood flow and biliary obstruction because of decreased removal. Other interferences are by cholecytogram dyes, opiates that cause spasm of the sphincter of Oddi, anabolic steroids and intravenous vitamin B. This test should be used with extreme caution because of complications such as thrombophlebitis, tissue necrosis with extravasation and occasional anaphylactic shock and death.

Many of the liver function tests give the same information and one should select the minimum number to arrive at the correct diagnosis. Screening profiles have revealed liver disease in apparently healthy individuals, especially anicteric hepatitis and chronic alcoholism. Most cases of proven liver disease can be detected by a screening panel of bilirubin, SGOT and alkaline phosphatase. The direct bilirubin and SGGT should be included in the profile but the SGPT usually will not add to the above tests.

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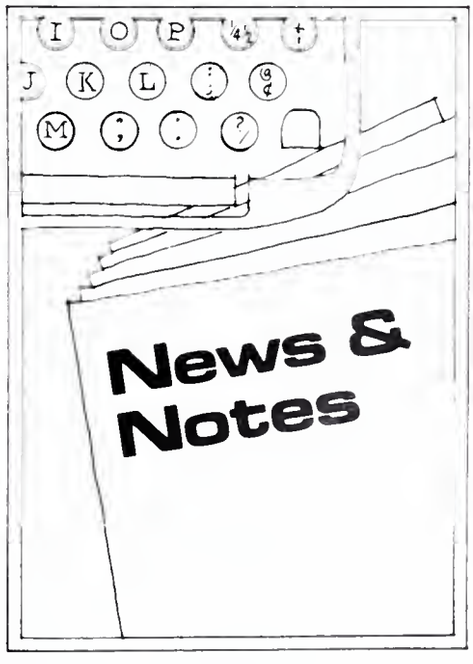
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HENRY N. YOKOYAMA, M.D.

Personal Glimpses

Irish emigrant and soccer player extraordinare, **Jack Keenan** was at a beach picnic and had just swallowed a chunky piece of steak he had bludgeoned with one of those disposable plastic knifes. Jack vaguely remembers a curious tightness in his chest before he woke up hours later in the Straub ICU. Happily, he doesn't recall collapsing, being given CPR, and later being resuscitated after arresting in ICU. A grateful Irishman later wrote to **Bill Hammon,** the attending physi-

cian, thanking him for his efforts. Jack added wittily: "A normal EEG on an Irishman probably doesn't mean much" (As retold by **Mike Okihiro** who saw the EEG. Mike feels that the moral of the story is not to use plastic knives to cut steak.)

Retired radiologist **"Tad" Jun Chuan Wang** and his wife Mabel were medical missionaries in Zaire until recently. In a New Year message to members of the Community Church of Honolulu, Mabel described how Tad had to learn Lingala (a trade language) to communicate with the natives and use French in his medical charts. "Yan Chin is still as busy as ever, and is still beset by as many frustrations. In Honolulu, he never got sick, but since coming to Zaire, he's been sick 3 times already and his weight is down to 112 lbs . . . He's had to make extra holes in his belt, and at times had to resort to safety pins to hold his pants up!" We are happy to report that Tad and Mabel are back safely in Honolulu . . .

Life In These Parts

Earlier in the year when it seemed that the HMA's EMS program may be terminated by the end of June for lack of funds, there was an outburst of support for the program . . . and the *Advertiser* was deluged by letters and cards with the same message and from the same printer urging that the program be saved. The Legislature got the message and voted $687,000 to keep the program going till another Federal grant will be forthcoming. The cards, however, kept coming in although the Legislative session had ended over a month ago. The *Advertiser* finally had to come out with an editorial entitled, "Psst! It's Saved," and stating: "We welcome cards and letters about all subjects when they are appropriate. But after an issue has been for all intents settled, it is rather strange to keep receiving them." (Ed: Enough is enough!)

Eleven-year-old Don Torres of Waimanalo who developed aplastic anemia left St Francis Hospital after the State's first bone marrow transplant. The transplant team was headed by **Livingston Wong** and a consultation team was head by Robert Gale from UC at LA. **Young K. Paik,** director of laboratories, St Francis Hosp. revealed that the donor was Don's brother Philip Jr. **Robert Wilkinson,** pediatric hematologist at Kaiser, reported that the cost of the transplant will probably in the vicinity of $30,000 to $40,000, most of which will be covered by insurance . . .

"And speaking of stunners, Miss U.S.A. Judi Anderson stopped by yesterday. Have a boyfriend, Judi? 'No, just jogging partners' . . . One lucky jogging partner she might have during her week's vacation at home on Wailupe Circle is Dr Virgil Jobe. She saw him jogging yesterday and yelled, 'Keep it up, I'll be joining you soon.' So encouraged, Virgil turned in his fastest run ever . . ." (Daacon)

In the wake of the news about paraquat-contaminated marijuana from Mexico, where both the American and Mexican governments have been spraying marijuana and heroin poppy fields with paraquat, Kauai police officials warned that the plantations do use the chemical on their fields and could conceivably contaminate marijuana growing in cane fields . . . Kekaha Sugar Company manager Thomas O'Brien revealed that plantation use of paraquat was even higher on the Big Island . . . Kauai District Health Officer Robert Melton has no doubts about its danger. "It **is** dangerous, and doctors have received notification from the federal government concerning its hazards . . . It's definitely a very toxic chemical if drunk or inhaled . . . It's known to be damaging to the lungs . . ."

A federally funded service for kidney patients in Hawaii and the Pacific Basin area, called the End-Stage Renal Disease Network Coordinating Council, has opened here. **Livingston Wong** is chairman, **Dudley Seto** vice chairman, and **Peter Mitsumori** secretary treasurer. **Sylvia Levy,** executive director of the council, said the program will be concerned with developing criteria and standards for patient care in kidney disease with the idea of seeing that high quality care is available at the lowest possible cost . . . The government is trying to establish criteria in this area in order to have some idea of how to go about establishing such criteria for other such diseases." Hawaii's Pacific Network is Area 1 of 32 network areas throughout the U.S. . . .

Paul Stevens and three other GP's at Molokai General Hospital take care of the Molokai population of 6,000 . . . Paul is concerned about the number of Molokai residents who go off-island for medical treatment because of local "scuttlebutt" . . . "People have a habit of talking stink about their hospital . . . There's no real reason to—it's a good facility . . . **Emmett Aluli** (of Hawaiian activist fame) has moved to Molokai to uplift the image, and eliminate the badmouthing of the whole health care system . . ."

Professional Moves

There's hardly a stir within the medical community for the month of May . . . Perhaps the usual flurry will come in July and August . . . FP **Lolita Quintal Resari** opened her office at the Waipahu Professional Center Bldg and pediatrician **Lawrence Frisch** relocated his practice to the Kahuku Hospital.

On Kauai, FP **G. R. Geroso** opened at Haleko Annex, Suite 101, Lihue, Kauai and pediatrician **Dianne Mary Alice Pizey** joined the Kauai Medical Group, Inc at Wilcox Memorial Hospital and Health Center . . .

The following information is for your edification. 1978 is the Year of the Horse by the oriental zodiac. It may be of interest to those born in the Year of the Horse (1966, 1954, 1942, 1930, 1918 and 1906) that they are skillful in paying compliments, and are popular and very cheerful, but also tend to talk too much. The Horse-year people are skillful with finances and quick in everything they do. They are wise, talented, and good with their hands. They are decorative and showy in dress and manner. Although clever looking, inside they are rather weak, esp with the opposite sex. They are impatient and hot-blooded and can be impassionate. They are independent and break away from family influence. During the first and 2nd phases of their life, the Horse-year people have trouble, but have a good life in the 3rd phase. The best marriages will be with Tiger-year, Dog-year, and Sheep-year people and the worst marriage will be with the Rat-year people. Bad marriages will be the Ox-year, Rabbit-year or another Horse-year person . . .

Miscellany

Late one night, a doctor was having trouble with his toilet. He called his plumber and said, "The toilet is stuck and won't flush. What can I do?" The plumber in a solicitous tone replied, "Throw 2 aspirins into the bowl and let it rest for the night. Check with me again in the morning." (As told by our golfing colleague, **Ralph Inouye)**

The husband was quite upset after a heated argument with his wife. He went to the bedroom, got out his revolver which he pointed at his temple. His wife cautioned, "Don't do that! You'll kill yourself!" He replied, "Don't worry . . . You're next." (Another golfing colleague, **To Tamura)**

Medical technology had so advanced that brain transplants had become feasible. A moron was killed in a car accident. The neurosurgeon summoned the family of a brain damaged patient and excitedly reported that a brain was finally available . . . "Your son is so lucky!" he bubbled. The anxious family asked, "Why is he so lucky?" "Why, the brain has hardly been used." (By golfing partner **Bob Kinoshita)**

A newly opened restaurant was advertising, "All you can eat for $1.98" A country bumpkin in town read the sign carefully and after much deliberation said, "I'll take two orders . . ." (Another Bob Kinoshita joke)

Sportsmen

Runners: The Primo Relays were held on May 28 at Hawaii Kai with 448 10-man teams participating. **Owen Kaneshiro** organized a team called "The Moving Experience" with himself and four other physicians, **Jim Musgrave, Gordon Ontai, Don Fancher,** and **Mark Kuge.** "The Moving Experience" placed 64th, and 49th in the men's organized division . . .

OB man **Gordon Ontai** had a delivery coming up so he moved up to 6:30 instead of his scheduled 8:30 run. Even

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then, as he was about to start, his radio pager started to beep so he handed the beeper to a friend and got off to a fast start and cut 3 minutes off his time . . . He still made it in time for his delivery . . .

Divoters: The annual DDD Golf Tournament run this year by the druggists was rained out on April 6 and played in May at Pearl Country Club . . . The physicians' group from St Francis took all the top honors . . . **Al "Tiger" Paraz** shot net 65 to win overall low net. **Al Chun Hoon** shot net 66 to win A Flight, **Catalina Cachero** shot net 68 to win B Flight and **Bill Dang** shot net 66 to win C Flight . . .

Elected, Honored & Appointed

The Rehabilitation Hospital of the Pacific reelected **William Davis** president . . . **Nadine Bruce** was elected Vice President, **Frederick Shepard, Chien-Fong Wu, Byron Young, David Pang, Maxwell Urata,** and **David Kimura** are executive committee members and **Dennis Crowley, William Yarbrough, Victor Hay-Roe, Thomas Walinski,** and **Fred Shepard** are patient care evaluation committee members . . .

Ray deHay, Kailua internist, was given a Special Recognition Award by the American Society of Internal Medicine (ASIM) at its annual meeting in San Francisco, for his distinguished achievements in the field of gastroenterology and his leadership in the Hawaii Society of Internal Medicine.

Edward Jones and **Don Newman** were selected on the Board of Directors of the revived Molokai Boxing Association.

The John Burns School of Medicine received $1,936 from AMA-ERF funds. More than 139 medical schools in the U.S., Canada and Puerto Rico receive these grants . . .

Hors De Combat

When the Governor releases the $250,000 appropriated by the 1978 Legislature for improved neighbor island EMS, Maui should get an additional ambulance service for the summer. Where to base this ambulance becomes a source of conflict . . . **Russell Pierce,** chief of the EMS branch, feels that the DOH is leaning toward Wailuku, probably Maui Memorial Hospital. **William Maschal,** president of the Kihei Community Association, feels that they need an ambulance service in Kihei with a 24-hour paramedic crew . . . An ambulance from Wailuku to the Wailea area of Kihei or Upcountry can take 45 minutes . . . **Mayor Elmer Cravalho,** who has long called for the state to place Maui's ambulance service under county control, was happy that under the new comprehensive legislation, the county can contract with the state to operate its own services . . .

After a 2½-year study, the Institute of Medicine of the National Academy of Sciences recommended that Federal and state governments which pay for medical care through Medicare and Medicaid and private health insurance companies should reimburse all physicians at the same payment level for the same primary service and that the proper fee should fall between the two extremes now existing between primary physicians and specialists. Such a move will remove the financial incentive for med students to choose highly technical specialties. E. Harvey Estes of Duke University, who headed the study group, says that about 90% of the medical care in this country could and should be provided by primary care practitioners . . . and medical schools should put more emphasis on training students in primary care . . .

Miscellany

Rufus had just joined the paratroopers . . . On the plane enroute to the jump zone, the instructor explained, "Now, when you jump, count to three and pull the red cord . . . If your chute doesn't open, then pull the blue one . . . If the reserve chute still doesn't open, don't you worry . . . There'll be an ambulance waiting on the ground." So Rufus jumps and pulls the red cord . . . Nothing happens . . . So he pulls the blue cord . . . Still no chute . . . As he plunges earthward, Rufus sez aloud, "Sure hope the ambulance is there . . ." (As related by **To Tamura,** our 19th Hole humorist)

As the foursome approached the 160 yard par 3 water hole, . . . the presumptuous golfer asked his caddy, "What should I use?" The caddy replied, "Hit a 6 iron." The golfer sez, "Psshaw! I can reach with an 8 iron." The caddy countered, "I'll bet you 5 bucks you won't make it." Soon his 3 buddies had bet $100 each that he wouldn't reach . . . The presumptuous golfer accepted all bets with all the confidence in the world . . . Then he went back to his bag and pulled out another ball . . . "I've decided to use an old ball . . ." he explained . . . (As told by golfing wit, **Ken Koga)**

Visiting Professor

It was a rare learning experience following visiting endocrinologist **Edwin Bierman** (U of Washington Med School) from hospital to hospital as he lectured on endocrine aspects of aging, vascular complications of diabetes, hyperlipidemia, and obesity and diabetes . . . The following are desultory notes gathered therefrom:

"Endocrine Aspects of Aging" (Lecture at Kaiser) Endocrinology and aging are intimately linked . . . Hormones are classified chemically as steroids and polypeptides . . . Steroids are mesodermal in origin and act within the cell . . . Polypeptides are neuroectodermal and act on the cell surface . . . There is constant feedback: pituitary to hypothalamus; endocrine glands to pituitary and hypothalamus.

Hormone blood levels are determined by synthesis and secretion rates, concentration, protein binding, metabolic degradation rates, and stimuli . . . Primary endocrine gland failure is rare: Examples are the female menopause and male endopause (6th and 7th decades) . . . Thyroid glands show no change in circulating hormones with age because of decreased tissue degradation and reserve glands responding to TSH stimulation . . . Adrenal glands: the circulating corticosteroids remain the same with age because of similar compensatory production and decreased tissue degradation.

Cell receptor diseases result from genetic defects in receptor function, antireceptor autoantibodies, hypersensitivity, and aging . . . eg. insulin receptor: blood glucose rises with age, but IRI (immunoreactive insulin) and IRG (glucagon) levels remain the same.

Glucose tolerance curves decline with age . . . By Cohn's criteria, 50% of those over 65 would be diabetic . . . The dilemma is how to diagnose diabetes after age 65 . . . The prevalence of clinical diabetes would rise exponentially with age since the parameters used are from young individuals.

Relative and absolute adiposity increases with age . . . Adiposity causes insulin antagonism which affects basal insulin secretion and insulin response to glucose.

Serum cholesterol rises with age: in males the peak is at age 50; in females, it peaks at age 60.

"Control of Hyperglycemia to Vascular Complications of Diabetes" (Lecture at Kuakini)

The controversy is still with us . . . The issue is whether or not hyperglycemia occurs parallel with or is directly related to these diseases (microvascular disease and atherosclerosis) . . . Joslin Clinic figures show that by 25 years, 65% have retinopathy, nephropathy, and peripheral vascular disease, and 92% have ASHD despite excellent control . . .

Juvenile-onset diabetes and adult-onset diabetes are genetically, clinically and pathogenically different:

	JUVENILE-ONSET	ADULT-ONSET
Family Hx	+	+++
MZ twin concordance	+	+++
HLA antigens	+++	0
Autoantibodies	++	+
Viral etiology	Possible	0
Islet cell antibodies	++	±
Islet cell morphology	Loss	Hyperplasia
Obesity	0	+++
Insulin resistance	0	+++
Insulin deficiency	+++	±
Vascular complications	?	?

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In insulin-dependent diabetics, the amount of brain damage is proportional to the number of hypoglycemic episodes . . . The UGDP Study showed that even with variable insulin therapy (over a 5 to 6 year period) there was no improvement in cardiovascular mortality . . . In JODM, retinopathy proceeds parallel with the duration of diabetes: within 1 year, 60% show microaneurysms.

The abnormal gene leads to generalized cell defects which cause (1) cell replication *in vitor;* (2) altered endocrine cell responses (which in turn affects production of insulin, glucagon, and growth hormones and results in hyperglycemia) (3) altered antibody response (affects autoantibodies) (4) endothelial cell death (causing capillary basal lamination and microangiopathology) (5) Schwann cell death (causing neuropathy) and (6) arterial (intima) cell death and altered repair.

"I do not use the GTT in adults . . . ⅓ are normal on repeat . . . I treat if the FBS is over 125mg% in juveniles or over 150mg% in adults up to 65.

The treatment of obesity in AODM lowers cholesterol, reduces hyperlipidemia, reduces blood pressure and prevents atherosclerosis. But restriction of calories is not for JODM for it can stunt growth . . . Weight reduction is the keystone in the treatment of AODM . . . Everything else is secondary . . . Weight reduction treats the pathogenesis of AODM . . . There is excuse for use of oral agents in only 5% of AODM patients.

"Hyperlipidemic States" (Lecture Straub Clinic)

Serum cholesterol peaks at age 50 for men and age 60 for women . . . Even with so called normal levels, there is a continued increased risk . . . Framingham Studies show a sharp rise in CHD even with cholesterol levels of 200 to 260 . . . Hyperlipidemia results from overproduction and underremoval . . . and is sensitive to insulin and thyroid hormone . . . Secondary exogenous lipemia is found in severe diabetes, myxedema, use of corticosteroids, dysglobulinemia, pancreatitis, congenital lipodystrophy . . . Primary exogenous lipemia is familial or sporadic.

Obesity, uremia, corticosteroids, growth hormones, and estrogens are insulin antagonists . . . They reduce basal insulin production and increase endogenous triglyceride synthesis in the liver . . . In the ddx of hypercholesterolemia, consider hypothyroidism, nephrotic syndrome, and obstructive liver disease.

The secondary causes of hyperlipidemia include obesity, alcohol, diabetes, hypothyroidism, chronic renal disease, and obstructive liver disease . . . The treatment is basic diet therapy (low fat, low calorie, low cholesterol, low alcohol, and high-fiber diet).

Alcohol raises the level of HDL which is a protective lipoprotein . . . The "therapeutic range of alcohol" is about 30 gms/d.

"Obesity and Diabetes" (Lecture at QMC, Kam Auditorium)

Obesity and adult diabetes make strange bed fellows . . . The prevalence of obesity in AODM is 80-90% . . . Is the cause of diabetes too much carbohydrate? Apparently not, for the higher the carbohydrate ingested, the lower the incidence (The poor eat more carbohydrate and are thinner).

Weight gain causes higher GTT curves and weight loss lowers the curve . . . Duration of obesity is related to GTT intolerance . . . Obesity, uremia, corticosteroids, growth hormone and estrogens are insulin antagonists to basal insulin secretion and raise the level of IRI . . . Thus fasting insulin rises with weight gain over ideal body weight.

Obesity increases the size of adipocytes, thereby reducing insulin receptors on the cell surface and increasing the insulin around the cell . . . thus the hyperinsulinism of obesity . . . Obesity causes insulin resistance and hyperinsulinism . . . (ie absolute insulin is increased, but is still insufficient).

When FBS is greater than 115 to 125mg%, there is loss of acute insulin response . . . When FBS is below 115mg%, there is a wide range of insulin response.

Overnutrition causes large adipocytes which are less sensitive to insulin . . . In simple obesity a/c carbohydrate intolerance, basal insulin rises and insulin response drops. . . . genetic diabetic trait is stressed by the degree of obesity . . . With weight reduction, the adipocyte shrinks, the FBS is lowered, and there is a return of acute insulin reaction . . . Weight reduction is the pyramid in the treatment of AODM.

In the genesis of AODM, there is an overlap of environment and genes. The major environmental factor is obesity . . . I do not diagnose AODM with the GTT . . . I use FBS greater than 125mg% (which means no insulin response) . . . We are making unnecessary diagnoses of DM with GTT curves. When we repeat GTT curves in one year, 40% will revert to normal, 40% will remain the same and 20% will worsen . . . Diabetes Mellitus is a syndrome consisting of microvascular disease, macrovascular disease and hyperglycemia . . . The important factors are a FBS over 125mg% and a family history of diabetes . . .

Humor From *Medical Economics*

(Submitted by Tom Leinweber)

"Easier Said Than Done"

"Pecker," in British idiom, means courage, and "keeping the pecker up" means "maintaining good spirits." As a newly arrived doctor in our small American town, my English husband inherited a large proportion of the patients in two nursing homes. He'd try to visit most of the old folks at least once a week. For those requiring no medical care, he felt a word of encouragement was in order. So, until a thoughtful colleague informed him of the nurses' horror at this dirty foreigner, he made it a habit, as he had always done, to pat each soul on the shoulder and tell each one "to keep your pecker up!" (Judith Egerton, MD)

"Wasted Time"

At the end of a routine visit, a male patient asked me if those "nature pills" worked. It seemed he'd been having trouble getting an erection. Trying to determine if this was functional or psychological, I asked him if he ever had morning erections. He looked puzzled, then said, "Yes—but what's the good of that, Doc? There's never anyone around then." (Robert Hodges, Jr. MD)

Miscellany

A male potato chip asked a female potato chip: "Are you FRITO-LAY?" (As told by **Ed Kagihara,** master MC)

A woman tourist in the Islands was fascinated by an exhibit of Hawaiian phallic symbols . . . She naively asked the male guide, "What's that?" Guide: "That's a Hawaiian phallic symbol . . ." Tourist: "I'd hate to tell you what it looks like . . ." (As told by our master wit, **Claude Caver)**

A demanding diner shouted, "Waiter, do you serve crabs here?" The waiter replied pleasantly, "We serve anyone . . . Please be seated." (Another **Claude Caver** joke)

I got a car called Camaro . . . When I honk the horn, it sez, "Arruda! Arruda!" And when I start her up, she goes, "Pacheco! Pacheco!" (Hope Holiona, a patient)

Our "Angels"

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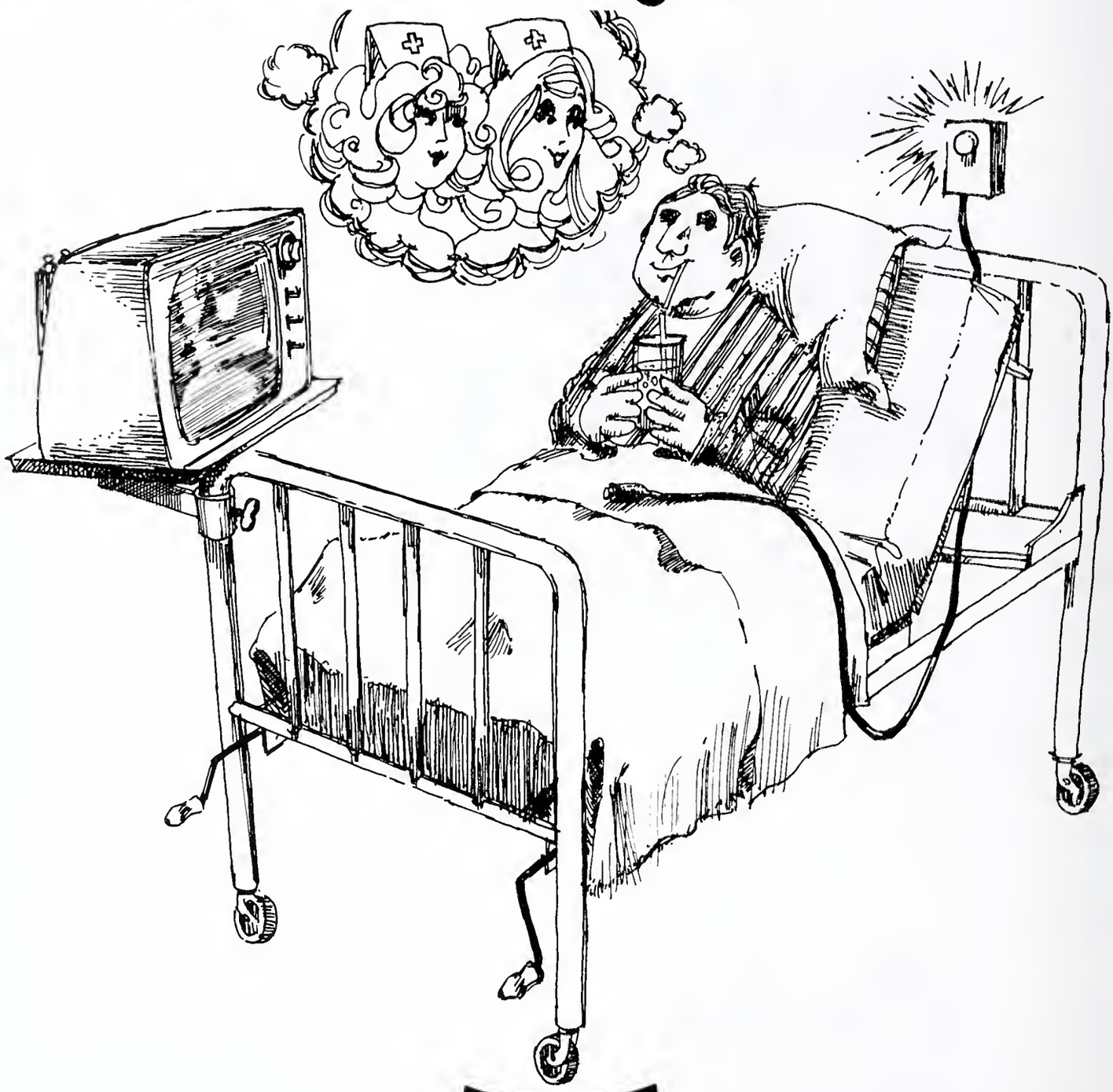
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Hawaii Medical Service Association

JULY, 1978
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Hawaii Medical Journal

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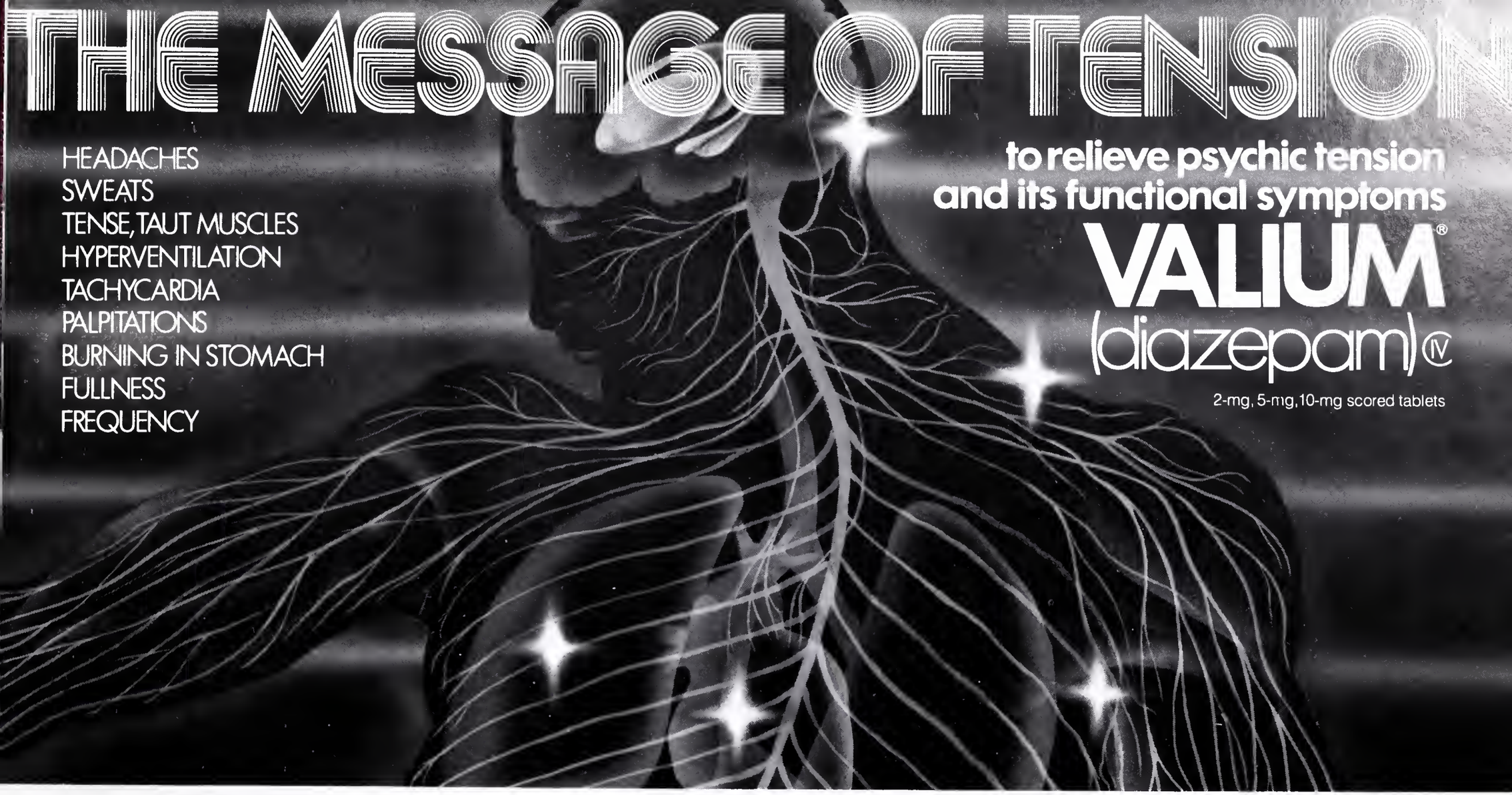
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VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy

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Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000, Persons When States Adopt Cooperating Laws–He Ca the Measure 'Cornerstone' of His Economic Program

WASHINGTON, Aug. 14, 1
The Social Security Bill, prov
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SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved [illegible] today, 94 to 0, and sen[illegible] o

TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

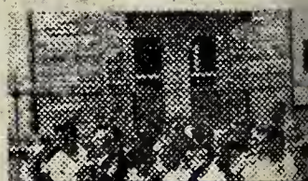
The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

UL IGNE the Draf Ends Nov

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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Stead, W.W. and Bates, J., in Harrison's Principles of Medicine,
8th Edition, 1977, McGraw-Hill, p. 900.



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Precautions: Tuberculin testing should be done with caution in persons with active tuberculosis. However, activation of quiescent lesions is rare.

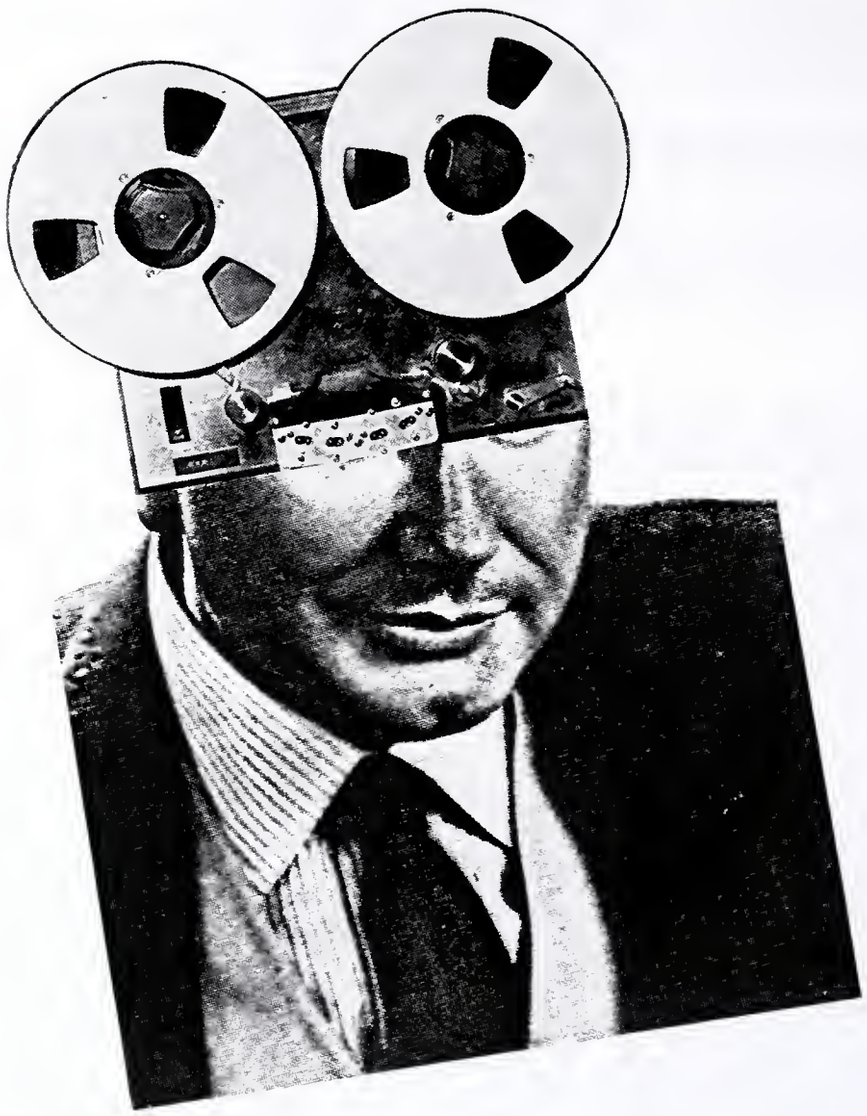
Although clinical allergy to acacia is very rare, this product contains some acacia as a stabilizer and should be used with caution in patients with known allergy to this component. Reactivity to the test may be suppressed in patients who are receiving corticosteroids or immunosuppressive agents, or those who have recently been vaccinated with live virus vaccine such as measles.

With a positive reaction, further diagnostic procedures must be considered. These may include x-ray of the chest, microbiologic examinations of sputa and other specimens, and confirmation of the positive TINE TEST using the Mantoux method. In general, the TINE TEST does not need to be repeated. Antituberculous chemotherapy should not be instituted solely on the basis of a single positive TINE TEST.

Adverse Reactions: Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons. Pain, pruritus and discomfort at the test site may be relieved by cold packs or by a topical glucocorticoid ointment or cream. Transient bleeding may be observed at a puncture site and is of no significance.

Reference: Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N.Y. 1969.

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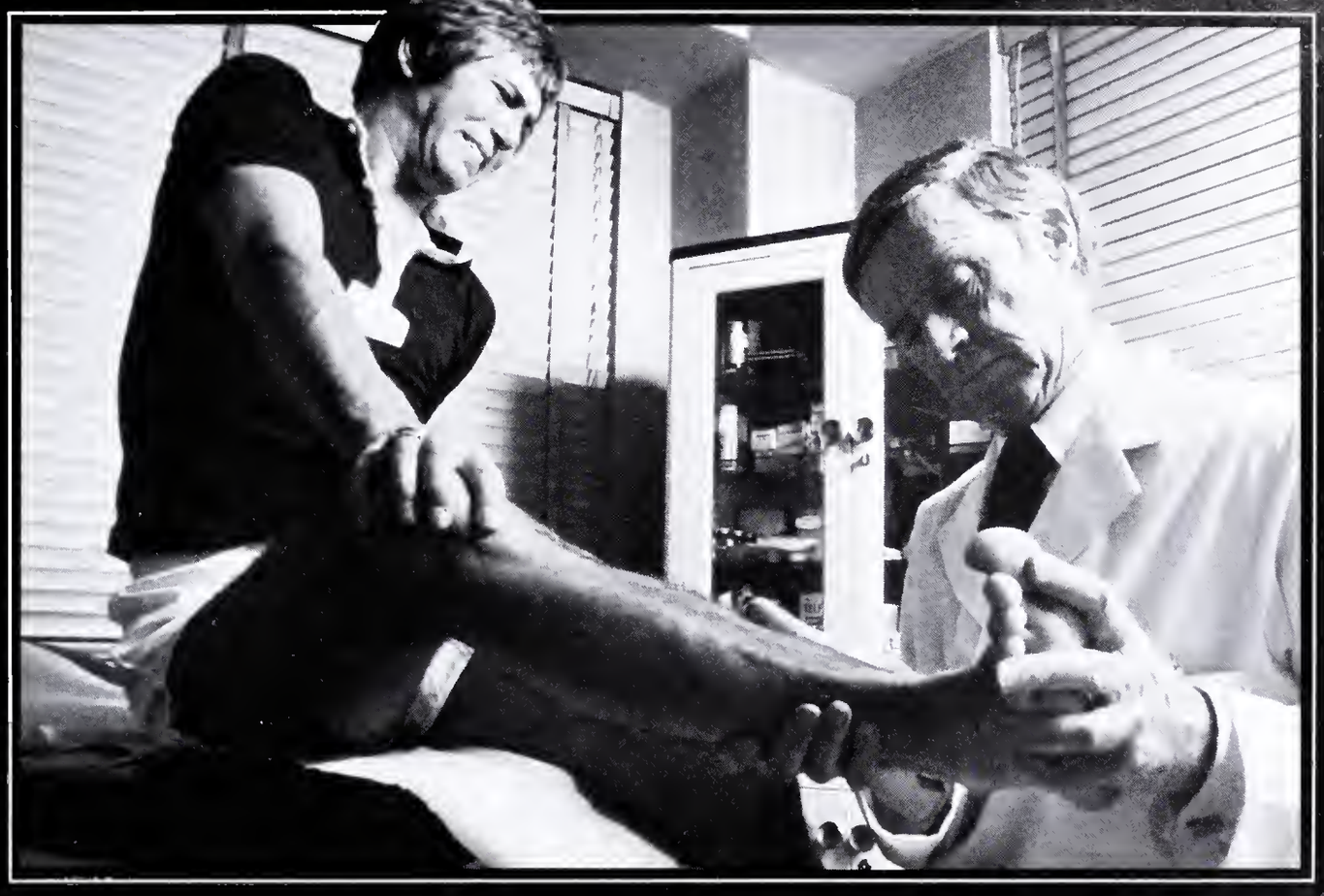
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The Emergency Medical Services Program of Hawaii, Part III: The Hawaii Medical Association's Training of Mobile Intensive Care Technicians (MICT's) as Pre-Hospital Paramedics

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• *In 1966, in an article mostly devoted to evaluation of in-hospital patient outcomes following resuscitation for cardiac arrest due to myocardial infarction, Drs. J. F. Pantridge and J.S. Geddes of Belfast, Ireland, briefly described a unique ambulance that was equipped to provide comprehensive emergency cardiac care* out of the hospital.[1] *This ambulance, a Mobile Coronary Care Unit (MCCU), equipped with an electrocardiograph, resuscitation equipment, a 7000-volt D.C. cardiac defibrillator, bipolar cardiac pacing catheters, and a resuscitation team from the cardiac department of the Royal Victoria Hospital,*[1-3] *subsequently made major contributions toward revolutionizing pre-hospital emergency medical care world-wide.*[4-5] *Pantridge and his associates demonstrated these changes with their reports of favorable statistics derived from out-of-hospital cardiac emergency resuscitation performed by their Mobile Coronary Care Unit.*[2-3, 5-11]

During the late 1960's and early 1970's many areas of the world,[3-4] including numerous centers in the U.S.A., established versions of mobile intensive care units to provide comprehensive pre-hospital emergency medical care by ambulance.

On January 8, 1973, the Emergency Medical Services Program of the Hawaii Medical Association began training Hawaii's ambulance Emergency Medical Technicians (ie, E.M.T.'s)[12,13] in 8-month courses to the level of Mobile Intensive Care Technician (M.I.C.T.),[13] to provide comprehensive pre-hospital emergency medical care to people of Hawaii involved in any type of medical or surgical emergency.

Heart Deaths Rising

Most centers in the U.S.A., including Hawaii, had nothing to lose by establishing mobile intensive care units, as exemplified by statistics obtained during the 1960's and 1970's. Whereas, in 1966, it was determined that in excess of 600,000 persons in the U.S.A. died from ischemic heart disease annually,[14-15] a subsequent evaluation revealed in excess of 650,000 Americans dying annually from ischemic heart disease, with 350,000 of these deaths (ie, 54%) occurring outside the hospital.[16-17] In 1972, annual ischemic heart disease deaths in the U.S.A. totaled 684,424,[18] with 357,844[18] of these deaths being attributed to acute myocardial infarction (the total number of deaths in the U.S.A. in 1972 was approximately 1,963,944).[18] Heart disease remains the number one cause of death in the U.S.A. and in the State of Hawaii. In 1972, Hawaii contributed 1,395

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ischemic heart disease resident deaths[19] to the 684,424 U.S.A. total, although the exact number of Hawaii deaths outside the hospital for this classification is not known from published sources. In 1975 Hawaii had a lesser number, 1,249, of ischemic heart disease deaths (ICDA numbers 410-414 for this category) among its residents.[20]

Observations made in other areas of the world [7-11,14,21-27] have repeatedly demonstrated the fact that out-of-hospital ischemic diseases of the heart and sudden cardiac death (as defined)[28] are often preceded by major cardiac arrhythmias. Similar cardiac arrhythmias probably accompanied a significant proportion of Hawaii's out-of-hospital nontraumatic cardiac emergencies during the 1950's, 1960's, and early 1970's. However, the training of Mobile Intensive Care Technicians (ie, MICT's) in Hawaii has allowed the MICT's to provide substantial documentation, since 1973, that out-of-hospital premature ventricular contractions, ventricular tachycardia, idioventricular rhythms, supraventricular bradycardia, third-degree atrioventricular block, ventricular electrical asystole, and numerous other electrocardiographic arrhythmias do occur in numerous cardiac and some non-cardiac ambulance patients.[29]

In the State of Hawaii, as elsewhere, it can be stated with certainty that persons rendering pre-hospital emergency medical care to a cardiopulmonary arrest victim are knowingly or unknowingly being confronted most frequently with patient ventricular tachycardia, third-degree heart block, implanted pacemaker failure/non-capture/runaway, idioventricular bradyrhythms, ventricular fibrillation, cardiac electro-mechanical dissociation, or cardiac electrical asystole . . . these arrhythmias have been confirmed with M.I.C.T. Quick-Look® E.K.G. oscilloscope monitoring and E.K.G. paper trace recordings.[29] In addition, for Hawaii's cardiopulmonary arrest victims, there have been several arrests secondary to trauma, including exsanguinating hemorrhage.[29]

Cardiac Care comes to the Patient

Significant pre-hospital cardiac emergency resuscitation success rates have been reported by centers that utilize personnel to appropriately utilize and integrate the techniques of cardiopulmonary resuscitation, E.K.G. monitoring, E.K.G. interpretation, cardiac defibrillation, administration of intravenous fluids, administration of intravenous medications, and ventilation adjuncts (e.g., bag-valve-mask, endotracheal intubation, *et al*).[2,3,6-11,14,21-27] Integrated comprehensive out-of-hospital emergency cardiac care is being provided by Mobile Intensive Care Technicians that have been trained by the Hawaii Medical Association's Emergency Medical Services Program; however, the statistical evaluation of several aspects of this pre-hospital emergency cardiac care on Oahu has only recently become available.

Cardiac emergencies are only one type of out-of-hospital emergencies that have been well documented.[4,21,29-37] Paramedic-staffed mobile intensive care ambulances in the U.S.A. on the East Coast[34] and the West Coast[21] have demonstrated that emergency calls involving cardiac cases usually comprise less than 30% of the total calls for the ambulance district specified. Even the specialized nature of mobile coronary care ambulances (ie, coronary patient predominence) does not preclude their providing care to patients of a non-cardiac nature as much as 33% of the time.[35] The fact that a significant percentage of out-of-hospital deaths, illnesses, and injuries in the U.S.A. are not primarily cardiac in nature[32,36-37] has apparently stimulated many areas, including Hawaii, to establish mobile intensive care units (MICU) that provide out-of-hospital emergency medical care for *all* types of medical and surgical emergencies, rather than establish mobile coronary care units (MCCU) that deliver pre-hospital emergency cardiac care almost exclusively.

Trauma Figures were Incentive

A major stimulus in the U.S.A. for the development of mobile intensive care units, per se, was provided by the trauma statistics of the 1966 publication *Accidental Death and Disability: the Neglected Disease of Modern Society*.[32] This publication indicated that "accidents are the leading cause of death among persons between the ages of 1 and 37," and also revealed that "in the past 60 years more Americans have died from accidents than from combat wounds in all of our wars."[32] Accidents are the fourth leading cause of death in the U.S.A.[36,37] with the U.S.A. having 117,000 deaths, 52 million injuries, and 420,000 permanent disabilities in 1972.[36-37] Accidents are also the fourth leading cause of death in Hawaii and, in 1972 resulted in the death of 252 residents of the State of Hawaii.[38] For all categories of accidents in 1972, traffic accidents in Hawaii resulted in 11,141 injuries and 146 deaths in that year (in 1976, 11,667 injuries and 149 deaths were reported).[39] All these traffic accident injuries and fatalities may be considered out-of-hospital emergencies.

These statistics indicated that, as of 1972 (or earlier), the U.S.A. and its State of Hawaii were definitely in need of mobile intensive care systems to provide integrated comprehensive pre-hospital emergency medical care to the numerous victims of out-of-hospital medical and surgical emergencies in a way which would reduce the previous morbidity and mortality. As Trunkey's trauma fatality autopsy study indicated, "the

quality of care is dependent on the type of vehicle used, its equipment, and most importantly, the quality and training of the individual who initially sees, assesses, and resuscitates the patient."[40]

Many training programs have been established in many areas of the U.S.A. since 1965 to train the paramedical personnel needed to staff the mobile intensive care units. Even though the mobile coronary care unit of Dr. Pantridge was physician- and nurse-staffed,[3] health manpower and health economics circumstances in the U.S.A. permitted only a few areas of the U.S.A. with the luxury of having mobile intensive care units staffed with only physicians and nurses.[3,35] The paramedical personnel once trained, proved reliable as "paramedics," and training programs for paramedics have blossomed into over 80 U.S.A. paramedic training programs.[41-42] Enabling legislation in the 50 states has helped greatly.[43] The role of the "paramedic," as emergency medical technician of an advanced nature (E.M.T.-Paramedic) has been defined as it relates to the emergency department[44] and as it relates to emergency medical services.[45-46] The roles of paramedics are being defined by the National Registry of Emergency Medical Technicians. The definition of the role of one type of paramedic for ambulance and fire-rescue services in Hawaii, the Mobile Intensive Care Technician or M.I.C.T., is described herein.

Definition of a Mobile Intensive Care Technician, Hawaii

The Mobile Intensive Care Technician, or M.I.C.T., is a professionally-trained medical emergency technician who is capable of delivering prompt efficient emergency medical care for the sick and injured *at the scene of the emergency* and during transportation to a medical facility. This is provided for under the auspices of HRS 453, State of Hawaii Revised Statutes. Specialty training in emergency cardiac care, trauma care, and other emergency care is required of the M.I.C.T. trainees, and successful graduation from a training program that is certified by the State of Hawaii Board of Medical Examiners, (Department of Regulatory Agencies, State of Hawaii) is required. The MICT is operationally defined by the MICT skills (as listed in Table 1), as permitted under the "physician-support personnel" section of HRS 453 "Relating to Physician-Support Personnel and Physician's Assistants" (Hawaii Revised Statutes 453-2, signed into law May 17, 1973). In reference to Table 1, it can be seen that a number of provisions do relate to the actual practice of medicine, hence the need for enabling State Legislation in Hawaii.

TABLE 1.—*Hawaii Mobile Intensive Care Technician (MICT) Skills*

1. All Hawaii Emergency Medical Technician (EMT-A) Skills[42]
2. Administration of Intravenous Fluids
3. Administration of Medications
 a. intracardiac
 b. intramuscular
 c. intravenous
 d. oral
 e. subcutaneous
 f. sublingual
4. Administration of Oxygen
 a. oral airway
 b. nasal cannula
 c. face mask
 d. mouth-to-mask
 e. mouth-to-mouth
 f. positive pressure (Elder-type valve)
 g. bag-valve-mask (e.g., Hope)
 h. bag-valve-tube
 i. endotracheal tube
 j. mouth-to-tube
 k. cricothyrostomy
 l. mouth-to-stoma
 m. nasotracheal intubation
 n. mouth-to-nose
 o. bag-valve with oxygen reservoir bag
5. Application of Heart-Lung Resuscitator
6. Application of Military Antishock Trousers (ie, MAST suit)
7. Application of Rotating Tourniquets
8. Assessment of Breath Sounds, by auscultation
9. Assessment of Chest Pain, detailed
10. Assessment of Neck Veins
11. Assessment of Vital Signs, detailed
12. BCLS 1-2-3-4-5 CPR Certification (American Heart Association standards)
13. Closed Chest Thoracostomy, needle, venting
14. Cricothyrostomy, needle, ventilating
15. Defibrillation, cardiac
16. Direct Laryngoscopy, foreign body removal (McGill forceps)
17. Dressing and Bandaging Wounds
18. Electrocardiogram, monitoring and interpretation
 a. rhythm strip
 b. 12-lead
19. Endotracheal Intubation
20. Examination, physical, detailed
 a. abdominal pain
 b. chest pain
 c. neurological
 d. multiple trauma
 e. other
21. Gastric Lavage
22. History, detailed, pertinent
23. Limb Immobilization
 a. card board, air, or improvised splints
 b. traction splints
24. Nasogastric Tube, insertion
25. Nasotracheal Intubation
26. Operation of Life Pak IV Cardiac Monitor-Defibrillator
27. Pericardiocentesis
28. Pharmacological Management of:
 a. acidosis (metabolic)
 b. acute myocardial infarction
 c. anaphylaxis
 d. asthma
 e. cardiac arrhythmias
 f. congestive heart failure
 g. convulsions
 h. fluid overload
 i. hyperkalemia
 j. hypotension
 k. insulin shock (and other hypoglycemias)
 l. pain

m. poisoning
n. post-partum hemorrhage, severe
o. pulmonary edema
p. tetany
q. other problems
29. Phlebotomy
30. Radio communication and Radiotelemetry
31. Spine, immobilization
a. cervical collars
b. short spineboard
c. long spineboard
d. scoop stretcher
e. other
32. Standing Orders, utilizes as appropriate
33. Suctioning
a. nasal
b. nasopharyngeal
c. oral
d. oropharyngeal
e. tracheal
f. bronchial
34. Synchronized Cardioversion
35. Thoracentesis
a. for tension pneumothorax
36. Vagocardic Stimulus (carotid sinus massage)
37. Venipuncture

The Curriculum of the MICT

The curriculum of the MICT is summarized in Table 2 and consists of 400 hours of classroom instruction, 175 hours of supervised clinical experience and 640 hours of supervised criteria-oriented internship (a total of 1215 hours over approximately 8 months). The course work is full-time, 40 hours a week. The course content is summarized in Table 3, for simplicity. A large number of practicing physicians in Hawaii contribute generously as the course lecturers, and their kokua is gratefully acknowledged (space limitations preclude full formal recognition here).

TABLE 2.—*Hawaii Mobile Intensive Care Technician (MICT) Curriculum*

Didactic (Classroom)	400 hrs.
Clinical Experience	175 hrs.
Internship	640 hrs.
Total Minimum Length of Course	1215 hrs.

TABLE 3.—*Minimum Curriculum Content for Classroom-Clinical Portion Mobile Intensive Care Technician (MICT) Training Program*

Didactic (Classroom)

	HOURS
1. Introduction:	2
2. Medical Terminology:	7
3. Vital Signs:	5
4. History and Clinical Assessment of the Emergency Patient:	11
5. CPR, HLR:	10
6. Respiratory System:	12½
7. Airway Management & Alleviation of Obstructions:	4
8. Oxygen Therapy:	1
9. Suctioning: Technique and Equipment:	1
10. Emergency Care & Treatment of Drowning & Other Water Accidents:	2
11. Systemic Circulation:	6
12. Physiology, Clinical Signs, Emergency Treatment of Shock, Hemorrhage and its Control:	6
13. Multiple Trauma:	6½
14. Acute Abdomen:	1
15. Nervous System:	11
16. Unconscious Patient:	2
17. Endocrine Emergencies:	3
18. Physiology & Differential Diagnosis of Diabetic Coma and Insulin Shock—Emergency Care & Treatment:	2
19. Renal Anatomy & Physiology:	2
20. Sterile Technique:	2
21. Signs & Symptoms:	4
22. Math: Computation of Drug Dosages:	14
23. Emergency Medications: Cardiac Pharmacology:	19
24. Administration of Medications:	28
25. Fluid and Electrolyte Balance: I.V. Therapy	2
26. Acid Base Balance:	3
27. Drug Abuse:	3
28. Poisoning:	1
29. Cardiology:	15 7½
30. Emergency Childbirth; Gynecological Emergencies:	5
31. Pediatric Emergencies:	9½
32. Psychiatric Emergencies:	3
33. Musculo-Skeletal Emergencies; Bandaging and Splinting:	5
34. Allergies; Histamine, Anaphylactic Shock:	1
35. Technique of Gastric Lavage:	1
36. Radio Communications; Telemetry:	9
37. Record Keeping:	4
38. Legal Aspects of MICT:	1
39. Exams: General, Mid Term & Final Exams; Evaluations:	34
TOTAL HOURS	400

Clinical

	HOURS
1. OB/Delivery:	14
2. Pediatric Emergency Specialty Area:	14
3. Emergency Room:	42
4. I.V. Team:	21
5. Coronary Care Unit:	21
6. Intensive Care Unit:	14
7. Operating Room:	7
8. Emergency Vehicle:	42
TOTAL HOURS:	175

The administration of medications by various routes is an important aspect of MICT skills, and a list of the medications which the MICT's are trained to utilize is found in Table 4.[47-48] Medication administration is very carefully supervised as to quality and quantity during the MICT training period. These medications, including indications, dosage, route of administration, complications, and side effects are succinctly and parsimoniously presented in Mrs. Reta Pozzi's *Handbook of Emergency Medications*, which is given to MICT trainees.

The training is divided into two very distinct phases, a classroom-clinical phase of 675 hours and an internship phase of 640 hours. These descriptions are precise indications of the training function. No certification of a trainee is

TABLE 4.—*HMA-EMS Program Approved Medications for MICT Ambulances Use Upon Order by Hawaii Licensed Physician*[47-48]

1. Aminophyllin
2. Atropine
3. Calcium Chloride
4. Dexamethasone (Decadron®)
5. Dextrose 50% in water, 5% in water
6. Diazepam (Valium®)
7. Digoxin (Lanoxin®)
8. Diphenhydramine (Benadryl®)
9. Epinephrine 1:1000, 1:10,000
10. Furosemide (Lasix®)
11. Glucagon
12. Hydrocortisone Sodium Succinate (SoluCortef®)
13. Isoproterenol (Isuprel®)
14. LTA Kit®
15. Lidocaine (Xylocaine®) 1%, 4%; ointment - 5%
16. Metaraminol (Aramine®)
17. Morphine
18. Naloxone (Narcan®)
19. Nitroglycerin (Nitrostat®)
20. Normal Saline
21. Oxytocin (Pitocin®)
22. Phenobarbital
23. Sodium Bicarbonate
24. Spirits of Ammonia
25. Syrup of Ipecac

made until the trainee satisfactorily completes both the classroom-clinical *and* internship phases. The trainee is fully evaluated by many persons throughout the training as to quality and experience.

The ability to use medical radiocommunications (MEDICOM) facilitates both the training and quality of medical care delivery to the patient. In Hawaii, the use of Mobile Intensive Care Technicians requires a medical MEDICOM System to link the in-hospital full-time emergency physician with the at-scene MICT, in order to legally provide the patient with medical care that may require involvement in acts constituting the practice of medicine. The emergency physician maintains a great deal of quality control over the patient care delivered and the training of MICT interns (who are directly supervised by previously-certified MICTs). Standing Orders, as specified in Table 5,[47] allow mobile emergency command through the MEDICOM radiocommunications requirement built into each standing order. Standing orders are just utilized provisionally.

The Mobile Intensive Care Technicians appear to be facilitating primary emergency medical care delivery, as integral adjuncts to physicians, 24 hours a day, 7 days a week for Hawaii's medical and surgical emergencies.

TABLE 5.—*MICT Standing Orders—Island of Oahu Approved by the HMA-EMS Executive Board*

If Patient Exhibits

1. Apnea
 (a) provide rescue breathing, bag mask ventilation with 100% O_2 or CPR until ready to intubate endotracheally
 (b) perform endotracheal intubation
 (c) communicate with E.R. physician for further orders
2. Systolic BP < 90 torr and exhibits signs of hypovolemic shock
 (a) start I.V. with normal saline and infuse at a rapid rate until the systolic *BP is > 100* torr or until the neck veins start to become distended
 (b) provide 100% oxygen via mask (or endotracheal tube if apneic), at least 6 L/min. flows
 (c) communicate with E.R. physician for further orders
3. Code 500 status (cardiac and/or respiratory arrest)
 (a) provide rescue breathing or CPR and start 100% oxygen ASAP
 (b) provide D.C. electrical defibrillation if pulseless from nonperfusing ventricular fibrillation or ventricular tachycardia
 (c) start I.V. with D_5W at KVO with microdrip apparatus
 (d) perform endotracheal intubation
 (e) administer $NaHCO_3$ at 1 to 2 mEq/kg body weight as an I.V. bolus
 (f) *administer epinephrine 0.5 mg to 1 mg (5-10 cc of 1:10,000 dilution) I.V. as a bolus for ventricular fibrillation, asystole or electromechanical dissociation. (FOR ADULTS ONLY)*
 (g) communicate with E.R. physician for further orders
4. Certain PVC patterns (R-on-T, 3 in a row or more, bigeminy, multifocal, coupled, or more than 5/min.)
 (a) give 50-75 mg. (or 1 mg/kg) Xylocaine® I.V. as a bolus
 (b) communicate with E.R. physician for further orders
5. Acute severe anaphylactic shock
 (a) administer epinephrine I.V. as 5 cc. of 1/10,000 dilution
 (b) communicate with E.R. physician for further orders
6. *Comatose or markedly stuporous patient*
 (a) *start I.V. with D_5W at KVO with microdrip apparatus*
 (b) *communicate with E.R. physician for further orders*

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Microcytosis, Iron Deficiency and Thalassemia Trait

JOSEPH M. ICZKOVITZ, M.D.* *and*
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• *Microcytosis and hypochromia are most commonly due to iron deficiency, but are also frequently seen in thalassemia trait. A simple calculation has recently been described for further differentiation of iron deficiency and thalassemia trait and utilizes discriminate function (D.F.) analysis of values readily available from the Coulter S counter. Case reports reveal the D.F. to be 99% correct in identifying iron deficiency and 82% correct in thalassemia trait. Of 30 patients with uncomplicated microcytosis (MCV < 80), serially selected from a predominantly Oriental patient population, 9 cases (30%) fit the D.F. criterion for thalassemia trait. There were 6 Filipinos and 3 Chinese. In a selected population, D.F. analysis proved to be useful in separating thalassemia trait from iron deficiency.*

Automation of the complete blood count by the electronic cell counter has made the red cell indices readily available to the clinician. The value of the mean corpuscular volume gives additional significance to any given level of hemoglobin. The most common cause of microcytic, hypochromic cells the world over is probably iron deficiency,[1] but in certain populations thalassemia trait must be considered as an important etiology. In an attempt to distinguish these two entities, Fraser and England[2] studied a group of patients with known thalassemia trait and a group with known iron deficiency, and derived a formula that enables differentiation of the two from values reliably available from the electronic cell counter. They derived a discriminate function (D.F.) and found that for a patient with microcytosis, a numerically *positive* value for the mean corpuscular volume (M.C.V.), minus the red cell count (millions of R.B.C. per mm^3), minus five times the hemoglobin (Hgb), minus 3.4, identified iron deficiency, whereas a *negative* value meant thalassemia trait. Values between 1.0 and −1.0 were uncertain and were to be interpreted with caution. The relative ease of computing the D.F. and the uniquely susceptible population of Hawaii prompted a study of its potential utility in identifying patients with thalassemia trait.

Methods

The accuracy of the D.F. was examined by combining Fraser and England's original results[2] with those of other investigators. In those studies, iron deficiency was diagnosed with a depressed serum iron and an elevated iron-binding capacity. Thalassemia trait was considered present with an elevated HbA_2 and no other abnormal hemoglobin present on starch gel electrophoresis.

Serial admissions to the Saint Francis Hospital, Honolulu, for the month of January, 1975, were screened. Patients selected had an M.C.V. less than 80, the lower limit of normal for the hospital. Patients were excluded who had an obvious source of bleeding, were pregnant, or had a diagnosis of chronic pulmonary disease. Hemoglobin values less than 9.0 gm% were also excluded, since thalassemia trait alone does not cause anemia of such a degree. For patients with uncomplicated microcytic indices, the D.F. was calculated using the formula D.F. = M.C.V. − R.B.C. − 5 • Hgb − 3.4.

Results

Since the original publication of the D.F., other investigators have described their results (Table

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1). Fraser and England originally found all 34 patients with iron deficiency had a positive D.F., and all but one of the thalassemia trait patients had negative values. Gimferrer *et al*[3] found 193 of 195 patients with iron deficiency to have a positive D.F., 37 of 44 patients with known thalassemia trait to be correctly identified, and 7 were uncertain. Schreiver[4] found the D.F. accurate in 19 of 20 patients with iron deficiency. He reported his thalassemia trait patients on the basis of sex and age, and found that in men and children, the D.F. worked well, but was not as satisfactory for women. The problem here was felt to be a complication of coexistent iron deficiency in women of childbearing age, or pregnancy, and these had not been excluded.

TABLE 1.—*Application of DF*

	IRON DEFICIENCY 249 PATIENTS			THALASSEMIA 179 PATIENTS			
	Pos	*Unc*	*Neg*	*Pos*	*Unc*	*Neg*	
Fraser and England, 1973	34			1		37	
Gimferrer, et al, 1975	193	1	1		7	37	
Schreiver, 1973	19	1		1		28	men
				17		28	women
				2		17	children
TOTAL	246 (99%)	2	1	21	7	147 (82%)	

When the results of these three studies are pooled, it is found that the D.F. is numerically positive in 99% of 249 patients with iron deficiency. In 175 patients with thalassemia trait, 82% are correctly identified. If the women in Schreiver's study are excluded, the percentage rises to 88% correct.

A group of 30 patients with microcytic indices were selected from 365 serial admissions to a Honolulu hospital. Patients with evidence of hemorrhage, pregnancy, or polycythemia were excluded. The race of the patients are shown in Table 2 and is a reflection of the hospital's racial population. The majority are of Filipino and Chinese origin.

The discriminate function was applied to the 30 cases, and the patients with values less than −1.0 are shown in Table 3. There were 9 in number, 30% of the total. Ages range from 18 to 69, with a mean age of 36. There were 7 men and 2 women. Filipinos numbered 5, 3 were Chinese, and 1 Filipino-Chinese. The M.C.V. ranged from 64 to 79, with a mean of 72. The R.B.C. was

TABLE 2.—*Racial distribution of patients with microcytosis*

Filipino	10
Chinese	9
Samoan	3
Fil-Chinese	2
Hi-Chinese	2
Puerto Rican	2
Japanese	1
Tongan	1
TOTAL	30

greater than 5 million per cubic milliliter in 7 patients. The M.C.H.C. was decreased in 6 cases. Target cells were seen in one case and basophilic stippling was not seen in any. A2 hemoglobin was elevated to 4.2 percent in one patient with a negative D.F. value. Serum iron and iron binding capacity were done in 10 patients with a positive D.F. value and the values obtained were indicative of iron deficiency or chronic disease. Bone marrow examination was not performed in any patient. Only one patient had a D.F. between 1.0 and −1.0, not easily interpretable.

Discussion

The discriminate function is a statistical method derived to maximize differences between two similar groups. The D.F. of Fraser and England employs values that are a part of the printout of the Coulter counter, and are therefore reliably available. The D.F. was accurate in differentiating 99% of 249 patients with known iron deficiency from 82% of 175 patients with known thalassemia trait. This is beneficial, especially since other methods of distinguishing the two may not be reliable. Basophilic stippling and target cells are conventionally thought to be distinctive for the thalassemia smear, but were notably not seen here. An elevated R.B.C. was found in the majority of our patients, but Pootrakul *et al*[5] found erythrocytosis in only 34% of 312 patients with thalassemia trait.

The restrictions of the D.F. must be kept in mind. Conditions which alter the R.B.C., such as polycythemia, either primary or secondary, the hemodilution of hemorrhage, or pregnancy, complicate the calculation. Exclusion of these conditions improves the accuracy of the D.F. In cases where iron deficiency and thalassemia trait coexist, the D.F. reflects the process that predominates in the bone marrow.[2] Iron therapy in such a patient would be indicated, and after cor-

TABLE 3.—*Patients with DF < −1.0*

AGE	SEX	RACE	MCV	HGB	RBC	MCHC	DF
69	M	FIL	71	14.3	6.61	30.3	−3.7
35	M	CHI	71	13.1	6.23	29.8	−2.6
35	M	FIL	75	14.2	6.16	30.5	−1.2
63	M	CHI	69	14.5	6.86	30.8	−6.9
19	F	FIL	65	11.7	6.21	29.8	−3.1
22	M	CHI	79	14.4	5.33	34.1	−1.7
18	M	FIL/CHI	77	15.2	6.15	32.0	−1.7
27	M	FIL	78	14.1	5.35	33.2	−1.2
40	F	FIL	64	11.6	6.15	29.8	−3.2

rection of the deficiency, the D.F. would show thalassemia trait.

Another method of easy identification of the two entities was suggested by Mentzer.[6] He proposed results equal to the D.F. with the formula M.C.V./R.B.C.—values greater than 13 tended to be iron deficient and those less than 13 were thalassemia trait. However, further investigation[3,7] found this less helpful and the D.F. to be more accurate despite its increased complexity.

The study of microcytic patients brings out another point. Many patients with thalassemia trait are not being evaluated or identified. Of our microcytic patients, ⅓ had thalassemia trait according to the D.F., which according to the cumulative results, is at least 82% correct. It should be emphasized that the Chinese and Filipino populations be included in the group of patients of Mediterranean origin who classically have thalassemia trait. This may be important from the standpoint of avoiding inappropriate treatment. Hemochromatosis has been described even in a previously normal patient resulting from iron therapy alone.[8] Iron therapy may be particularly hazardous in thalassemia where the active bone marrow may be stimulating increased iron absorption. Ali[9] reviewed the medication history of a group of patients with thalassemia trait, and found 39% had received iron therapy. Further, hemochromatosis has been seen in patients with thalassemia trait in the absence of supplemental iron.[10] Times of secondary stress, such as pregnancy or infection, requires folate supplement to support erythropoiesis.[11]

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JON WON

TV-Radio Committee Involved in discussions with KHET-TV public television for airing of HMA-produced health series, "Health Conversations." Other TV stations have expressed some interest in doing similar programs. Much physician time and talent, all voluntary, have been put into the production of this series that has generated good relations between the medical profession and the public. A tip of the hat to all of you physicians who have participated! But many more physicians are needed. Dr. Henry Yokoyama is Chairman, if you're interested.

New Telephone Directory listing closing time is right around the corner, and physicians have been contacted during the past few months regarding listing in the white pages and the yellow pages of the telephone directory. Listings for white pages close September 1st and yellow page listings close August 11th. Would like to remind physicians that the current guidelines for such listings by HMA encourage physicians to list themselves under those specialties and/or subspecialties recognized by the AMA. These recognized specialties and subspecialties are listed in the 1977-78 HMA Roster on page 15. There are a total of 73 recognized categories so you should be able to find at least one that fits your particular case. Also, if you are to be listed under more than one specialty heading, HMA guidelines note that you should be board certified in all specialty and subspecialty areas under which you are listed.

Public Affairs Committee of HMA and Public Relations Committee of HCMS have been very active in developing communication mechanisms and approaches to establishing or improving internal communications with the membership as well as communication links with the general community. Program developments by the County Public Relations Committee relative to a patient newsletter, tentatively on a monthly basis, with health education material and health tips, have generated much patient interest. A pilot program of the first edition of Hawaii Health Tips (brought to the patient as a service of his or her doctor and the HCMS) has produced highly favorable response from patients and physicians. More information will be forthcoming soon. Other county societies have expressed interest in this approach.

HMA Annual Meeting, believe it or not, is right around the corner, October 2-6, 1978, at the Ilikai Hotel. The AMA Regional Continuing Medical Education program will be held in conjunction with our Annual Meeting again this year. For further details, call the HMA office. Also, Annual Meeting time means a new year for your professional association. The incoming president will be considering appointments for HMA committees and needs to have your participation. Please let us know what areas you are interested in so that the president will know you are interested.

HEW Secretary Califano has announced his intent to prohibit physicians and other health care providers from dominating boards of Blue Shield, Blue Cross, and private insurance companies that handle Medicare and Medicaid claims. He stated, in regard to claims review, "Those who have a financial interest in the outcome of these decisions should not have the power to make them." Question: Who *doesn't* have a financial interest in the outcome of such decisions?

Recent Califano attacks on what he calls exorbitant increases in physicians' fees have much irony. While increases in physicians' fee component of the Consumer Price Index is projected at *99.8%* from 1970 through 1979, the increases in HEW's budget are projected at *248%* for the same time period, and the increases in the federal debt interest payments are projected at *179.5%*.

Physicians' Fees Rose 0.7% in May, 1978, while the increase for all items was 1.0%, according to the government's Consumer Price Index. In April, 1978, physicians' fees rose 0.6%, again less than the 0.8% increase for all items.

The AMA Has Endorsed major disease prevention legislation introduced by Senator Edward Kennedy (D.-Mass.). The bill, S. 3115, would give federal grants to states to assist in costs of planning and providing health services, with special emphasis on hypertension, fluoridation, environmental causes of disease, rodent

control, physical fitness, and preventing paint poisoning.

A National Institute of Medicine Report recommends that primary care physicians should be "gatekeepers" for secondary and tertiary care. The report also recommends that a system, based on the British National Health Service, be developed to limit reimbursement for primary care to a specific level, with higher payments for more sophisticated services, and that physicians be required to limit their practices to one or the other category.

Interesting To Note That The British National Health Service celebrated its 30th birthday recently. The service now has 18 administrative and clerical workers for every ten physicians, including physicians in training. A new National Health service dole system is being instituted in which less healthy regions receive proportionately more money than the healthier ones. The new system has apparently angered the teaching hospitals because they feel that their status as "centers of excellence" is being eroded and that they will soon be reduced to a mediocre level. Earlier, at an AMA seminar in London, Maurice Miller, M.D., vice-chairman of the Labor Party's Parlimentary Health Group, discussed the plan to limit resources in the "centers of excellence"—teaching hospitals and medical schools—in order to redistribute funds to underserved areas. Dr. H. Thomas Ballentine, AMA Trustee, asked Dr. Miller if the Labor Party was prepared to settle for a "level of mediocrity" in the quality of medical services delivered to the people of Great Britain. Dr. Miller replied, "Yes, so long as the services are distributed equally." Nuff said!

HEW's Second Opinion Program has started. The first offer by HEW to establish such a program went to PSRO's. Hawaii's PSRO had much discussion regarding the need for such a program and many PSRO board members felt that the proper place for such a program should be in organized medicine. However, when the alternatives for other qualified organizations for such a program included insurance carriers, fiscal intermediaries, or state Medicaid agencies, the Pacific PSRO accepted the responsibility (with HMA and HCMS support). However, HEW has now modified its approach. It has discovered that many county medical societies already have an existing referral service which services patient requests for second opinions. Thus, the current approach is to offer those county societies with an existing referral program the opportunity to list their telephone numbers with HEW as the referral source. All four county medical societies in Hawaii have accepted this responsibility. More later.



The 1978 Shattuck Lecture in Boston

The *New England Journal of Medicine* June issue included the 1978 Shattuck Lecture—the prestigious annual presentation to the Massachusetts Medical Society in May. This year, it was given by a non-physician: Alain C. Enthoven, Ph.D, whose credentials as an economist from California are perhaps only slightly marred by the admission in the Journal that the lecture, "in part" was supported by the Henry J. Kaiser Family Foundation. It is entitled: "Cutting Cost without Cutting the Quality of Care."

Enthoven starts out well: "Generally speaking, studies have shown that such controls (Certificate of Need, price controls, Medicare and Medicaid reimbursement limits, the proposed Hospital Cost Containment Act of 1977) are ineffective."

However, he then goes on to say that the "main alternatives to increasing direct economic regulation" are to create a system "economical in the use of resources."

He blames current high costs of medical care on a) fee-for-service, b) hospital cost reimbursement, and c) third party intermediaries, all of which "reward the provider of care for cost-increasing behavior." He states: "From the point of view of the provider, there is apparently an unlimited amount of money."

This, we must admit, is true. However, we challenge his statement that this "open-ended" system "rewards cost-increasing practices with more revenue," and therefore, that physicians are motivated by the dollar rather than by what's best for their patients.

Is this perhaps true? That the practicing physician orders X-rays and laboratory tests, CAT-scanners and angiograms, needle biopsies and colonoscopies just because he, the particular physician, may and will derive additional revenue thereby and therefrom? We hope not!

It cannot be true of the solo practitioner. He has long since been interdicted from splitting

fees or owning a drugstore. Modern physicians hardly ever take and read their own X-rays. In this day and age of potential malpractice suits, and of certified qualified laboratories, few solo physicians or even small groups have the temerity to run their own lab tests.

It could be true of the larger groups, of course, because each physician-member does, in fact, split his fee with his group colleagues. And, herein lies an anachronism little mentioned: The government, which is seemingly the most concerned over cost-control, favors these large group practices over the solo physician, claiming that unit costs for the consumer can be reduced as a result of mass usage. Enthoven, in his lecture, favors such mass usage and, therefore, regionalism, but ignores the fact that the savings in "cost" are almost never passed on to the consumer in lowered charges.

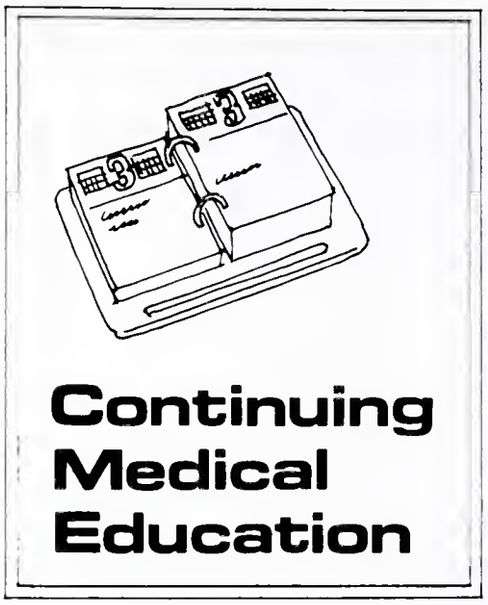
Ah, but hold on a second! The government is wily; it knows that it is but a step from a group that practices comprehensive total medical care under one roof, to an HMO, wherein there exists an imposed "lid."

Enthoven cites Kaiser-Permanente, the Group Health Cooperative of Puget Sound, Ross Loos and the Harvard Community Health Plan as the best known HMOs for having built-in incentives for economy. He also mentions an analysis done by Luft of the experience from 1950 to the present that reports a 10 to 40 percent reduction in cost, mainly attributable to a lower rate of hospitalization, greater economy and greater efficiency of operation. Not recognized, or not admitted, is *the* main *dis*-incentive to full quality care within these institutions: That it is to the physicians' dollar benefit to skimp a little, or a lot, in ordering tests or treatments for their patients!

Enthoven goes on to review a wide gamut of other plans, a plurality and a wide choice for consumers, to be sure. However, speaking of Individual-Practice Associations such as the Foundations for Medical Care (he includes by specific mention Hawaii's Medical Service Ass'n) he states: "The less hospitalization, the more (dollars) left over for the doctors." What an indictment that is! It is obviously the patient—the "consumer"—who suffers, or maybe comes close to suffering, so that the doctor can make more money!

This year's Shattuck Lecture, nevertheless, is worthwhile reading for all physicians interested in the future of medical practice in the U.S.A. It is pertinent particularly to the impending legislation in the Congress for a National Health Insurance Plan for the country. The one big fault with Enthoven's treatise, may be because he sees things as an economist and not as a physician, is that a consideration of medical care cannot be based on cost/benefit statistics; the practice of medicine is highly individualized—a one-to-one relationship between doctor and patient.

J.I.F.R.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/ Maui Mem. Hsp.

John A. Burns School of Medicine

1. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
2. U.H. Cardiology Grnd. Rnds., 1st Tues. 5:30 p.m. Rm. 506 Univ. Tower, Queen's.
3. UH Grand Rnds-Ob/Gyn, Wed. 7:30-8:30 a.m. Kapiolani Hsp. Aud.
4. UH Perinatal Conf., Thurs. 3:30-4:30 p.m. Kapiolani Hsp. Rm. 815.
5. UH Seminar, 2:30-3:30 p.m. Kapiolani Hsp. Rm. 826. Fridays, 1st-Pathology; 2nd-Perinatology; 4th-Journal Club.
6. UH Conf., Friday, 3:30-4:40 p.m. Kapiolani Rm. 826.
7. UH Visiting Prof. Program for Ob-Gyn, Quarterly.

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.

3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.

(Contact CME Dept.-Kaiser for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Kapiolani Maternity Hospital

1. Tuesday Conference, 1:00-2:00 p.m. Kapiolani Hsp. Aud.
 1st—Didactic Presentation
 2nd—Perinatal-Neonatal Topics
 3rd—Obstetrics Topics
 4th—Gyn Topics
2. Neonatal Grand Rnds., Friday 8:00-9:00 a.m. Kapiolani Hsp. Nursery.
3. Tumor Board-Oncology Conf., 1st & 3rd Friday, 1:00-2:00 p.m. Kapiolani Hsp. Aud.

Kuakini Medical Center

1. Visiting Professor Programs
2. G.I. Conf., 3rd Tues, 8:00-9:00 a.m.
3. Ophthalmology Departmental Mtg., 1st Tues. 1:00-2:00 p.m.
4. Medical Mortality & Morbidity Conf. (Dept. of Med. Mtg.) 4th Tues. ea. month, 1:00-2:00 p.m.
5. Nephrology Conf., 4th Tues., 8:00-9:00 a.m.
6. Oncology Conf., ea. Thurs. 7:30-8:30 a.m.
7. Surgical Conf., 1st Friday, 1:00-2:00 p.m.
8. Surgical Mortality & Morbidity Conf. (Dept. of Surg. Mtg.), 4th Friday, 1:00-2:00 p.m.)

(Contact CME Dept.-Kuakini for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
6. SFH-UH Surg. Sat. Teaching Rnds. (except 4th) 7:30-8:30 a.m. UH 4 Classroom.
7. SFH-UH Hematology Conf., 4th Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
8. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
9. Tumor Conf., ea. Monday, 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Cardiac Surgery Meeting meets the 2nd Tuesday of the month, from 4:30-5:30 p.m. in the Doctor's Dining Room.
3. Friday Noon Conference meets weekly, from 12:30-1:30 p.m., in the Doctor's Dining Room.
4. Medical Grand Rounds meets the 1st Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.
5. Orthopedic Conference meets quarterly, from 7:30-9:00 p.m., in the Doctor's Dining Room.
6. Quarterly Professional Meeting meets the 4th Monday of the month, from 7:30-8:30 p.m., in the Doctor's Dining Room.
7. Surgical Mortality and Morbidity meets the 4th Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu
Type: I, 1 hr./day, 1 day/mo. from 12 mos.
Fee: None Methods: AV, O, Pan
Dates: All yr., 12 hrs. instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: I, 1 hr./day, 1 day/mo. for 8 mos.
Fee: None Methods: AV, Clin C, O, Pan, R
Dates: Arranged; 8 hrs. instruction

SPECIAL EVENTS

August 5-12, 1978	USC School of Medicine-Ophthalmology, Mauna Kea Beach Hotel, contact Peter Millati, Fitzpatrick Travel Service.
August 12-19, 1978	USC School of Medicine post graduate refresher course, Sheraton Waikiki, Peter Millati, Fitzpatrick Travel Service.
August 26-Sept. 4, 1978	Post Grad. Education for Professionals—U of C Schl. of Med. Held at Mauna Kea Beach Htl. Contact: Barry S. Ramer, M.D., Director, U of C Schl. of Med. Calif. 18 hrs. Cat. I.
Sept. 20-23, 1978	Genetics & the Pediatrician—What Every Ped. Should Know.—Held on Oahu & Maui. Contact: Wilma Schiner, Workshop Coord. Kapiolani-Chldrn's Hsp. 1319 Punahou St., Honolulu, HI 96826 for further info.
Sept. 28-Oct. 7, 1978	Am. Acad. of Family Phys. 1978 Invitational Scientific Congress. Roger Tusken, Exec. Dir. 1740 West 92nd St., Kansas City, MO 64114. Held at Maui Surf Htl.
Oct. 1, 6, 1978	122nd HMA Annual Mtg. & AMA Regional CME Mtg. Ilikai Htl. Ala Moana Blvd., Honolulu. Contact: Mrs. Bess Chang at HMA for further info.

Oct. 2-6, 1978	Western Dialysis & Transplant Soc. Held at Hilton Hawaiian Village, Honolulu. 12 hrs. Cat. I. Contact: Arnold Siemsen, M.D., General Program Chairman, (808) 547-6522.
Oct. 8, 14, 1978	Am. College of OB/GYN. Held at Sheraton Waikiki/Kauai/Maui/Kona Surf. Cat. I. Contact: Wm. Hindle, M.D. 888 So. King St., Honolulu 96813, Ph. (808) 523-2311.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



New Members



Kenneal Y.C. Chun, M.D.

550 South Beretania Street
Honolulu, Hawaii 96813

OTOLARYNGOLOGY



David B. McEwan, M.D.

550 South Beretania Street
Honolulu, Hawaii 96813

FAMILY MEDICINE



Niranjaw Rajdev, M.D.

550 South Beretania Street
Honolulu, Hawaii 96813

INTERNAL MEDICINE/
HEMATOLOGY-ONCOLOGY



James Michael Sullivan, M.D.

888 South King Street
Honolulu, Hawaii 96813

INTERNAL MEDICINE/ER

Hawaii Academy of Family Physicians' Newsletter

J.I. Frederick Reppun, M.D.

New Members—George Roger GAY MD is a new Active member practicing in Hilo and a transfer from California; he is a Fellow, AAFP as of 1975 and ABFP 1976. **Capt. Robert H. MAJOR MD** is a new Resident Affiliate at Tripler. **Gary M. SUNADA** is a new student member, UHSM '79. We welcome all of you to our chapter.

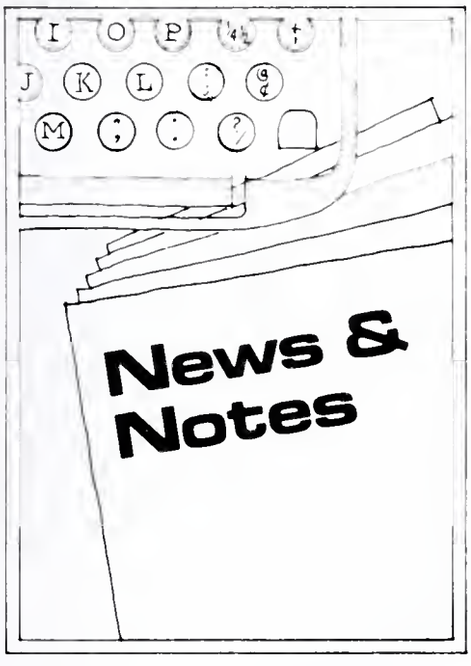
News of Members—Pat DIETRICH appeared, or is to appear twice on TV channels 9 and 2 under the sponsorship of the American Heart Ass'n—interviewed Corryel, Conover and Sam Gresham MD about Hypertension. The smart sponsor goes for the photogenic doctor, n'est-ce pas? The **James TSUJI's** have welcomed a son, Charles, into this world. Congrats!

USC-UHSM-TAMC—"The Big One," 12 to 23 August for lots of "P" credit, most of it in Honolulu but also on Maui and Kauai. Don't forget the **Annual Scientific Congress** in San Francisco, next door, 25 through 28 September; it is followed by the AAFP Invitational Scientific Congress at the Maui Surf 29 Sept. to 4 Oct., which, in turn, is followed by an "exciting extension to the Orient 5-17 October." The Maui part is good for 16 hours of 'P.' Lots of CME become available!

Computer Printout—this brings us to some items you store away in your own computer memory bank (brain!). Whenever you attend a formal course or program, take along your *YELLOW* Reporting Form—Card A of the AAFP CME. It has your name and CME number on it pre-printed. Fill out the back with the EXACT name of the course, etc., enter 'P' or 'E' and sign it. You can leave it with the course sponsor, who is to mail all he collects to AFFP in Kansas City. If you forgot to bring your card, fill one in from your stock at home and mail it yourself to Kansas City, NOT TO JEAN! The *GREEN* card in your packet is for you to send in just after the end of the calendar year; it is a total of your year's attendance at all other CME experiences that are not formal courses and sessions, i.e. your attendance at hospital departmental and CME meetings, etc. (see list), whether 'P' or 'E.' You can keep your own list of such affairs attached to the green card to help you tally at the end of each year. DON'T EXPECT JEAN TO TALLY SUCH UP FOR YOU! It is YOUR responsibility to keep track of your own hours of CME. The AAFP Computer is there only to

help you out and to give you a printout for you to check and verify. This printout will come to you annually in December (dates assigned to Hawaii). The computer will list your CME as 'ND' or "Non-designated" unless YOU specify for the computer whether your CME was 'P' or 'E.' Also, and VERY IMPORTANT, you must enter on your yellow card the EXACT title of the course or session, or the computer will not recognize it, remember it, or recall it for the printout. Clear? Auwe!

ALL of our more-or-less bi-monthly *dinner meetings* have been, are and will be 'P.' The next one is on Saturday night 29 July at **Don FARRELL's.** Bring your YELLOW card!



HENRY N. YOKOYAMA, M.D.

Bulletins

Doctors Challenge Lawyers . . .

Myron Shirasu, Doctor's Division Chairman for the Aloha United Fund this year, has bet his counterpart Attorney Huber of the Lawyer's Division that we will beat the lawyers. Both the lawyers and doctors have similar stated goals of $75,000. Last year 400 of the more than 1,000 physicians in the Islands contributed a paltry $69,000. Paul Tamura, vice chairman of the Professional Division, is also taking bets that we can beat our parsimonious traditional adversaries . . . Myron plans to send out appeal letters and then if no response, he will have our colleagues go out to solicit personally . . . The campaign starts in September . . .

HMA Convention

The 122nd Annual HMA Convention will be at the Hilkai from Sunday Oct 1 to Friday Oct 6. The HMA-AMA Clinical Sessions will feature fluid and electrolyte balance. Sportsman's Nite will be on Wednesday Oct 4 following the annual golf tournament that day at the Mid Pacific Country Club. The banquet will be on Friday Oct 6. The various sporting events, including deep sea fishing, skin diving, tennis and ping pong, will be held as usual. Please call Bess Chang at the HMA office for more details . . .

Sportsmen

The 2nd Annual DDD Tennis Tournament was held on Apr 2 at the Leeward Community College where 19 doubles teams fought furiously. When the dust finally settled, in first place was the team of pediatrician **Ben Chang** and orthopod **Gerald Dericks.** In 2nd was an "odd couple," a Tripler pediatrician named **Takai** and a dentist named Mullins . . .

Humorist Alan Luning's Repertoire

Clyde, the Iowa farmer, was having a bad year. First the drought wiped out his crops . . . Then the cows all died mysteriously . . . Finally the hired hand ran off with his pretty young wife . . . "Dear God," prayed Clyde, "What did I do to deserve all of this?" A clap of thunder, a flash of lightning, then a booming voice from up above: "Dimmo Clyde, but there's something about you that really irritates me."

The moron with a brand new pair of slippers was shuffling along slowly and pigeon-toed. A curious bystander asked, "Aren't you supposed to remove the strings?"

Professional Moves

We have three paltry announcements for June thus far: OB Gyn man **Bunzo Nakagawa** relocated his Wahiawa office from 960 Center Street to 302 California Avenue; pediatrician **Janice Smolec** joined the Fronk Clinic—Pearlridge; and cardiologist **William Freud** will have offices both at Pearlridge and the Honolulu office of the Fronk Clinic . . . We expect the usual deluge in the next two months . . .

Elected, Appointed, & Honored

At the June Annual Meeting of the Hawaii Heart Association, **Samuel Gresham** was elected president for a 2 year term; **Douglas Bell** was elected president-elect; and **Irwin Schatz** vice president. Special awards were presented to outgoing president **Danelo Canete** and also to **Morton Berk** for his 30 years of volunteer work. Elected to the board were **Dale Adams, Russel Carlson, Vincent Friedewald, Steward Matsumoto, Richard Reeve, Jeffery Sol** and **Stephen Wallach** . . .

Thomas Mar of Kailua, Hawaii received the U of Dakota's Sioux Award, the highest award given by the UND Alumni Association. The executive vice president of the Alumni Association described Tom Mar as one of the friendliest and most thoughtful individuals. Tom was football team physician for Hawaii Prep Academy and for Konowaena High School. He served with the Kona Civic Club, the Kona Rotary Club, the Free Masonry, and the Aloha Temple Shrine. He helped organize and was president of the High Twelve Club of Kona and the Kona Shrine Club . . . (Ed.—Did he also practice medicine?)

Miscellany

The new arrival from Hong Kong had scraped up enough to open a small chop suey place. He stood proudly before his spanking new sign: "Wong's Chop Suey." Happenchance he looked across the street at the sign, "Joe's Spaghetti House . . . Open 24 hours." Further down the street was "Stein's Deli . . . Open day and night." Flustered, but not outdone, Wong added to his sign, "Me No Sleep Too!" (As told by HCMS secretary, **Irene Wong**)

Life In These Parts I

"Revolt of the Nurses . . ."

The recent American Nurses Association (ANA) Convention held here supported the passage of a national health insurance program . . . outgoing president Anne Zimmerman of Chicago said, "This isn't the first time we have taken a position in conflict with the AMA." Sonya Herman, who has a PhD in nursing science and who authored the book "Becoming Assertive—A Guide for Nurses", feels that nurses need assertiveness training. "Traditionally, nurses have been the handmaidens of physicians. The hierarchy of authority in hospitals is such that the doctor is at the top in a god-like position, nurses are next and patients last."

"Kona Gold and Gold Lung" . . . It appears that "Gold Lung" is a potential problem of heavy smokers of "Kona Gold" marijuana sprayed with paraquat used on Big Island

cane fields. The marijuana-paraquat controversy came to a head when HEW Secretary Califano warned that users of marijuana sprayed with paraquat could lead to irreversible lung damage. There are many who contest this allegation . . .

"Talk Story" . . . **Kazuo Miyamoto,** retired physician, scholar and creative writer who authored "Hawaii, End of the Rainbow", was a panelist at a "Talk Story" conference at Mid Pacific Institute in June. Kazuo, who was one of 300 Hawaii Japanese rounded up as potentially dangerous citizens, describes life in internment camps and relocation centers in his book as seen through the eyes of a hospital worker. Kazuo characterizes his fellow camp inmates as "people who won't revolt when there is hope."

"Cost Containment?" Kapiolani Hospital raised its room-rates from $89 to $97 a day. Nursery fees went up from $45 to $65 a day and premature nursery fees rose from $55 to $75. Cost of abortions (during the first trimester) will rise from $300 to $315 . . .

"Strep Infections" . . . **Danelo Canete,** outgoing president of the Hawaii Heart Association, reported that 15% of 11,042 children tested by the association's rheumatic fever detection program had possible strep infections and were treated last year . . .

"The MMH and DOH Controversy" . . . After an uneasy truce of 6 months, the Maui Memorial Hospital nursing staff members were again testifying before the State Senate Health Committee with nearly identical testimonies about the critical staff shortages. DOH had assured Senator Anson Chong, committee chairman, that "there are currently 290 warm bodies now on the payroll, as compared to 275.5 in Dec last year. Eighty-one were hired in the last year and the bulk in the last 6 months." The hospital reports 19 vacancies and 10 persons on leave despite massive hiring efforts for a net total of 261 persons. Each person emphasized that staff and equipment shortages endanger the lives and health of all . . . When the dust settled, the real issue came to light with the statement by **Richard West,** "As long as Maui Memorial is in government hands, with bureaucrats making decisions, it will always be second rate." Along came Chief of Staff **William Kepler** who reiterated that MMH should be turned over to a private management group . . . "Up to 6 weeks ago, despite the drawbacks, I would have said it's improved, but another bandaid has fallen off with an increase in the census and a decrease in nursing staff."

"Biofeedback Wins Respectability" . . . A growing number of psychiatrists and psychologists use biofeedback with other forms of therapy to treat physical and mental illnesses. UH Med School Psychiatry Dept Chairman **John McDermott Jr.** reports that biofeedback is included in the psychiatric residency program. John feels that biofeedback has changed the traditional thinking about the separation of voluntary and involuntary nervous system. **William Cody,** Kaiser Hospital psychiatry chief, adds that "Biofeedback takes the approach that if you can show people that their bodies are reacting to certain stimuli, they can alter the patterns." Ned Murphy, director of psychiatry at the VA, has used biofeedback extensively and feels that "what we have believed for centuries is probably inaccurate and that the mind can correct certain bodily malfunctions with the assistance of biofeedback equipment." Psychiatrist Byron Eliashof is using biofeedback extensively to treat chronic pain and certain stress-related skin disorders. Byron says, "Biofeedback treats symptoms, not causes." John McDermott warns of possible misuse by unqualified persons. "The danger in it is the people who exploit it, the quacks who advertise that they can cure anything with it. People are awed by machinery and unscrupulous people take advantage of this."

"Personal Pathologist?" "Who says doctors don't make house calls anymore? Jimmy Borges received a visit at Trappers from his personal pathologist, **Dr. James Navin** of the Straub Clinic." *(Hyatt on the Beach)*

"Blood Bank Service" **Julia Frohlich,** medical director of the Blood Bank of Hawaii, reassured Maui residents who do not have its own full time blood donor center that "years of service to the outer islands by both the Hawaiian and Aloha Airlines with the Blood Bank of Hawaii has resulted in fast and efficient delivery under most circumstances."

Miscellany

The town's church was in dire financial straits (as many churches are these days). Father Joseph had heard that farmer Jones had an unusually fast galloping donkey . . . So he persuaded farmer Jones to sell the donkey for a worthy church cause . . . Then the Father entered the donkey in the town's annual horse races. The galloping donkey won the first day's race by a wide margin . . . The town daily headlined the event, "Father's Ass Out Front." The Bishop was scandalized. His Eminence lectured Father Joseph about ecclesiastical dignity and horse racing and forbade him from entering the donkey in the next day's races . . . The headlines read, "Bishop Scratches Father's Ass!" Father Joseph forthwith donated the donkey to the convent nuns. This prompted the headlines, "Nuns Have Best Ass in Town." The furious Bishop ordered the nuns to get rid of the now famous donkey. The nuns took the donkey to the town market place and sold the donkey cheap. The transaction was headlined: "Nuns Peddle Ass for Ten Dollars." His Eminence read the headline and promptly had a heart attack . . . (Also by our dentist wit, Ken Ozaki)

Life In These Parts II

"Hawaii's Legionnaires' Disease Panic" . . . On June 23, DOH announced to the press that a patient who had died 2 weeks earlier at QMC was Hawaii's first case of Legionnaires' Disease as confirmed by CDC in Atlanta . . . To avert any panic, next day, a QMC spokesperson announced that Legionnaires' disease is not believed to be transmitted by person-to-person contact, that the 31-year-old woman was a new arrival from California and that she may have had the disease before coming to Hawaii. Next day, **Richard Frankel,** infectious disease consultant on the case, explained that the antibodies were higher than the maximum reported in published figures and that the antibodies could have been in the patient's blood from some prior bout, and that she had died

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of pneumonia rather than Legionnaires' Disease. The DOH also issued a subsequent statement saying they were in accord with Dick and that there was no cause for alarm. Only by June 28 was the full story told; that the 31-year-old woman was a severe diabetic who had loss of vision in one eye, had kidney failure, had one leg amputated and a kidney transplant a year ago and that she had died of respiratory failure compounded by meningitis, pneumonitis and uncontrolled diabetes (Methinks someone goofed in releasing information to the press without getting the full details of the case.)

"EMS" . . . Not everyone was happy when the statewide emergency medical services system was signed into law by the Governor . . . Deputy City & County Health Director **John McDonald** felt that the measure had drawbacks . . . viz, that medical insurance premiums will rise when the State Health Department begins assessing fees; that the State will have to establish the bureaucratic mechanism for collecting fees; that the City will have to turn over an effective and efficient ambulance service to a "cumbersome" State Health Dept . . .

"Definition of Death" . . . House Bill 258 became a law, but the new law requires a neurologist be called in to determine if the brain has ceased irreversibly, thus creating a problem for the outer islands which have no EEG equipment or resident neurologists . . . The HMA feels that the bill is better than no bill at all since we will be less vulnerable to malpractice suits and the defects therein are expected to be amended at the next session . . .

"Bakke Case" . . . Dean **Terence Rogers** reported that he was "immensely pleased" that the UH Med School programs are in accord with the U.S. Supreme Court decision . . . Terry said, "Since the beginning of this school in 1965, we have conducted special programs to create new opportunities for the disadvantaged . . . We are glad that the Supreme Court appears to be saying that this is legally as well as morally right."

"National Health Insurance" . . . **Patricia Putnam,** UH Med School assistant dean, was a panelist at the 45th Annual Meeting of the Western Branch of the American Public Health Association. "Hawaii's Prepaid Health Plan Act could be a model for the Country when Congress enacts a national health insurance program . . . The State law requiring employers to provide health plan coverage to employees is a giant step forward . . . It isn't a panacea, but we have achieved things here other states are still striving for." Fellow panelist HMSA's Al Yuen favored a national program with private insurance plans and private physicians to permit competition, but ILWU social worker, vocal Ah Quon McElrath, maintains that the State's prepaid health plan has preserved the fee-for-service system and has done nothing to reduce physician's fees. Ah Quon says most of the bills in Congress follow the same lines allowing fee-for-service rather than a reasonable salary for physicians and preserve the third party payment approach which also perpetuates high costs. UH's Donald Char feels that innovative approaches should be looked into so consumers could be offered incentives to maintain health, rather than the consumers feeling that what insurance premiums they have paid for, they have the right to get out . . .

Miscellany

"How do you differentiate a male chromosome and a female chromosome?" "By pulling down their genes." (**Mike Okihiro** heard this one at a recent neurological meeting in S.F.)

Hors de Combat

The AMA House of Delegates is considering the findings of a special commission which spent 2 years studying the problems of soaring medical costs and now recommends promoting price consciousness. Theodore Chilcoat, assistant executive VP, said, "The aim is to strike a balance between price and quality. This is a change from an attitude where cost was no consideration in providing quality health care . . .

New HEW guidelines approved in March may set minimum requirements on the number of hospital beds, procedures performed and occupancy rates . . . Patrick Boland of the SHPDA (State Health Planning and Development Agency) feels that the agency may call for the closure of the open heart surgery units at Straub and St. Francis Hospitals; the OB unit at Pearlridge Hospital; pediatrics units at Queen's and Pearlridge; and the cardiac catheterization units at Kuakini and St. Francis. Re CAT scanners, Boland commented, "I call CAT scanners the 'clash of cymbols' . . . Everybody wants one." Physicians have mixed views on the new guidelines . . . One called it "Just another step toward socialized medicine." Another criticized the fact that Kaiser Hospital is exempt because of its HMO status . . .

From a profound article, "Ethical Dilemmas Physicians Face" written by Gardiner Jones, director of Public Affairs at the UH Med School, we extracted the following: "The physician struggles with ethical dilemmas that would try the judgment of Solomon; he is a scientist, but must often function as a moral referee on profound, even frightening questions for which there are no certain answers . . ." John McDermott: "Medicine has become so complicated with so many options that decisions depend on moral standards . . . Informed consent requires that we pay more attention to the moral skill . . ."

Attorney Donald Beck feels "medical ground rules are best established without resort to law on the theory that individual cases ordinarily constitute a feeble basis on which to determine principle" and insisted that "nevertheless risks must be explained." **Thomas Whelan** disagreed: "As a physician I have been always taught to try to bring comfort. Do I always do that if I tell all the things that could go wrong? . . . I don't make light of legal opinion, but how far do we go? . . . Although the underlying disciplines of medicine such as biochemistry are exact sciences, the practice of medicine itself is not and must take into account the vagaries of human nature . . . There are times when disclosure can have harmful effects on a patient already fearful and distraught; effects that actually interfere with therapy underway . . . We have to recognize the limitations we have in coming to decisions . . .



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The important thing is the feeling you have for the patient . . . You have to love the patient and if you do love, that is the greatest gift." Dean **Terry Rogers:** "If I were to use one word to describe a good doctor, I would use 'responsibility' . . . Medical ethics is not a code or a set of precepts separate from you . . . It's got to be part of you, and your medical ethics are just a part of your ethical approach to life and the responsibility you take toward the world . . . Considering the career choices you have made, what the hell is wrong with the idea that you make some sort of priestly dedication . . . A code in itself is inadequate. I would start with absolute responsibility . . . Once a week, for the rest of your lives, look at the reasons you have for becoming a doctor. It will keep you on the right track."

Sharon Bintliff: "Humanity and compassion are absolute musts in facing ethical dilemmas and we have no answers . . . Each case is decided on its own and I am never absolutely comfortable . . . 'Learn never to say 'never' and never say 'always.'"

U.S. Representative Cec Heftel has introduced a bill that would prohibit health insurance carriers from receiving federal contracts if their board of directors are dominated by physicians or hospital administrators. Cec feels that the bill will loosen the medical profession's control of health care costs. "It is a classic conflict of interest when insurance carriers controlled by the medical profession set high rates and premiums that the public must pay right back to the physicians and hospitals."

In June last year, the U.S. Supreme Court ruled that it was unconstitutional for professional societies to bar members from advertising. The decision dealt with an Arizona lawyer's case, but paved the way for doctors and dentists as well. The Federal Trade Commission in an antitrust action against the AMA alleges that it stifles competition by keeping members from advertising. The FTA contends that doctoring is a business and physicians should get out there and vie for patients by lowering fees and becoming more competitive. The ruling of an administrative law judge is expected this Fall . . .

Our "Angels"

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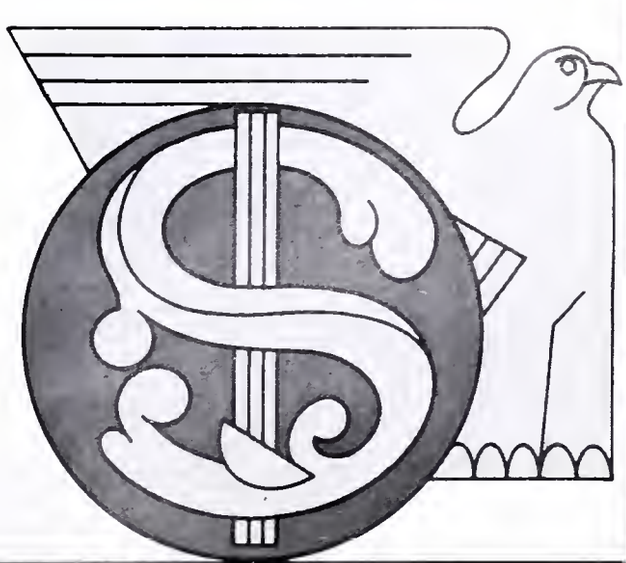
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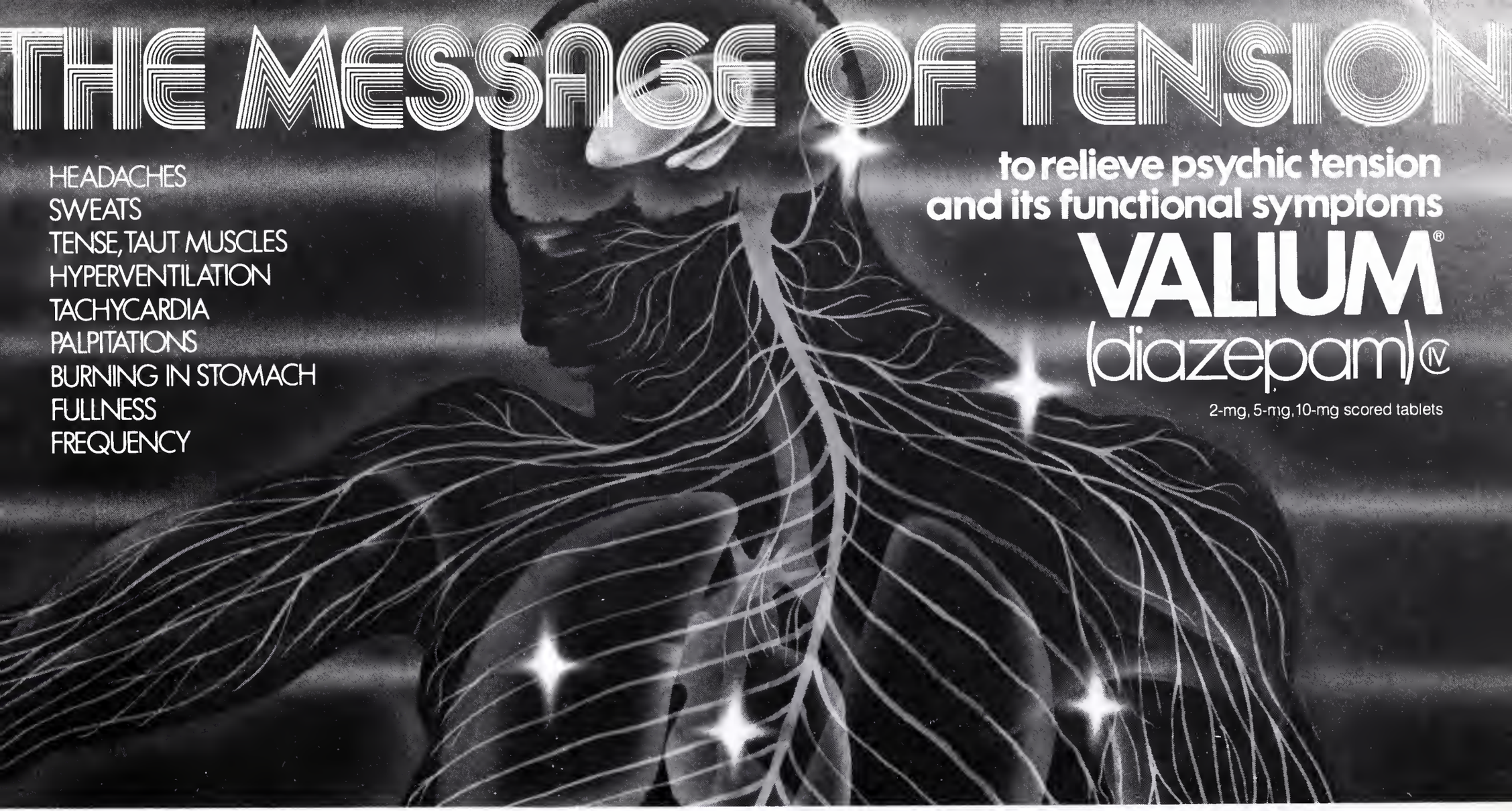
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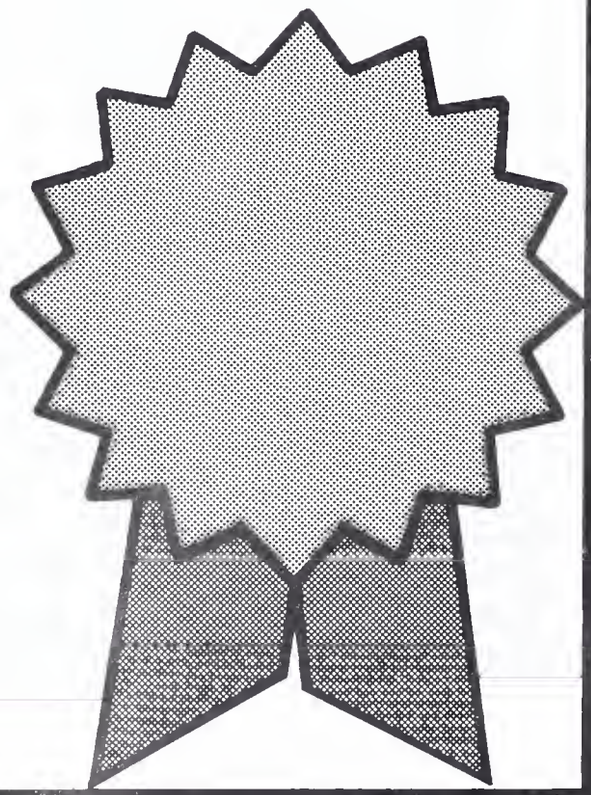
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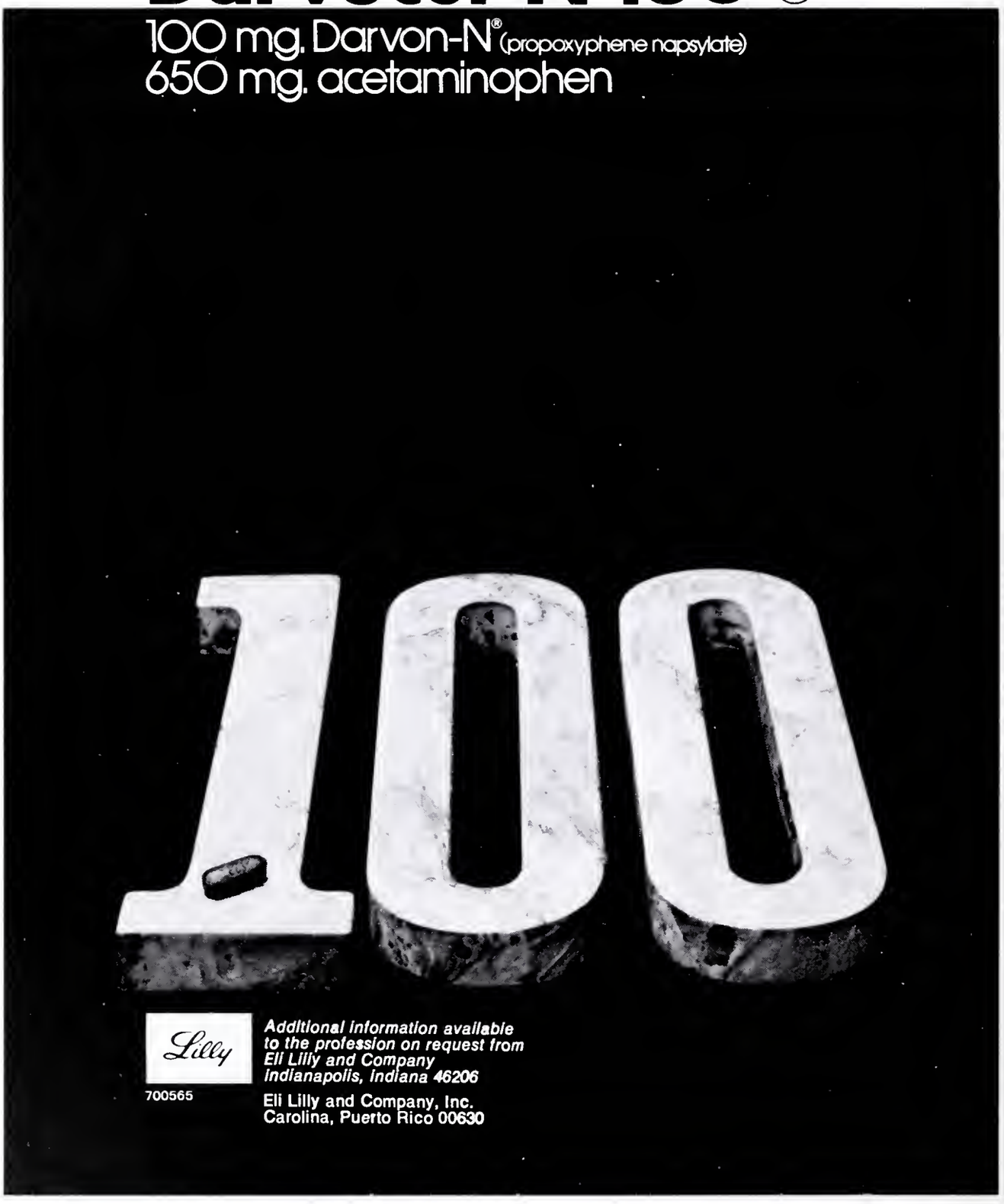
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The Use of Pre-Operative Collection Autotransfusion

KATHLEEN L. TUCKER, M.D., *Honolulu*

During the past 5 years at Kaiser Foundation Hospital in Honolulu, pre-op blood collection and storage (POCS), a type of autotransfusion, has been used extensively with excellent results. This method is most useful in patients with a normal hematocrit for whom transfusion will be needed during elective surgery, and who are thought to be free of significant coronary disease.[1]

Method

Reviewed were the charts of 73 patients who received autotransfusions in one or more operations at KFH during a period extending from 1972 to 1977. In each case, the blood was collected within 18 days prior to surgery, with an average of approximately 6 days between phlebotomies when multiple units were collected. The patients were placed on 0.3 gm $FeSO_4$ po TID for 30 days pre-operatively, and, following each phlebotomy, 50 mg imferon was given intramuscularly. CBC, VDRL, HB,Ag, and antibody screens were performed on most of the units, and the blood was crossmatched prior to reinfusion. When available, the patients' hemoglobin and hematocrit prephlebotomy, pre-operatively, post-operatively, and one month post-op, were recorded.

Results

We collected 162 units from 73 patients for use in 80 operations; 47 of these patients were men, 26 were women. In 7 patients, autologous units were collected for more than one procedure. Most of the units were used for either vascular or orthopedic surgery. Of the units collected, only 9 were not used (94% utilization). Of the 73 patients, 57% needed additional homologous units; 43% used only their own blood during and after surgery. Table I shows the average hemoglobins and hematocrits prephlebotomy, pre-op, post-op, and approximately one month following surgery. Complications which could be directly associated with blood infusion were rare: 1 transfusion reaction followed infusion of a concomitantly administered homologous unit; 4 patients hand hematuria, 1 had "excessive bleeding," and 2 had elevated bilirubin. In all these cases additional homologous units had been given.

TABLE 1.

	WOMEN	MEN
Prephlebotomy hgb/hct	12.7/37.1	14.1/41
Pre-operative hgb/hct	12.0/35	12.4/36.4
Post-operative hgb/hct	10.6/30.8	11.6/34.1
1 Month post-op hgb/hct	12.4/36.4	12.0/37.2

Discussion

Immediately after blood loss, the body tries to compensate by vasoconstriction and addition of fluid to the bloodstream. Plasma volume begins to increase immediately after hemorrhage and continues to do so for the next 48 to 72 hours, at which time plasma volume is approximately equal to the plasma volume before hemorrhage, plus the volume of red blood cells removed.[2] The body's ability to replace lost blood is therefore not limited by how fast the plasma can be replaced, but by how fast the red blood cell mass can be replaced, and the main limiting factor is the amount of iron present.[3] Patients who rely solely on their own iron stores after phlebotomy have a

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maximum RBC production rate of 2.8 to 3.2 times normal. If they start out iron-depleted but are given oral iron, production rates are 2.9 to 4.0 times normal. If the patient originally has adequate iron stores and in addition is given oral iron, production rates rise to 4.1 to 4.8 times normal. If endogenous iron stores are supplemented with intravenous iron dextran or repeated infusion of nonviable RBC's, an increase in marrow production of 4.5 to 7.8 times normal can be obtained within 10 days. These increased rates of production correlate well with serum iron levels. Erythroid bone marrow production is further enhanced if the hematocrit is lowered to 25 to 30%.[4]

Besides providing an additional source of blood and therefore decreasing the demand for homologous blood, POCS autotransfusions have other advantages.

1) They can be life-saving for the patient who needs elective surgery and has a rare blood type, or who is difficult to crossmatch because of the formation of an antibody following previous transfusions or childbirth.[5]

2) Routine crossmatching completely disregards any tissue antigen incompatibilities of platelets or white blood cells in the unit, which could lead to future transfusion reactions by stimulating formation of antibodies.[5]

3) Any homologous transfusion entails the injection of foreign protein into the recipients. In 1.5% of cases, the patient will develop an allergic reaction and in 0.1 to 0.2% they will have severe urticaria or an asthmatic reaction.[5,6] Less exposure to all types of antigens by reinfusing autologous blood would decrease the number to which an individual is sensitized.

4) There is decreased risk of transmitting disease from donor to recipient. Of people transfused with 2 units of blood, estimates show that 0.5% will become jaundiced and 14% will have non-icteric jaundice with an elevation of SGOT or SGPT. Although these percentages can be decreased by not using commercial donors (approximately a 70% reduction) and carefully interviewing of all those who do contribute their blood, many donors are unaware that they have had non-icteric jaundice and transmit the disease unknowingly. Screening with the HB$_S$Ag test is helpful in reducing the number of hepatitis contaminated units given, but experience has shown that it detects only about 25% of infections.[5,6] Of those patients who do receive HB$_S$Ag positive blood, approximately 40% will develop clinically identifiable hepatitis.[7]

Transmission of syphilis is not a problem currently because of VDRL/RPR testing. Most of the spirochetes are cold labile and will not survive if stored at 4 to 6°C for longer than 3 to six days. Malaria can be a problem in an endemic area, especially since the parasites can survive days and even weeks when stored at 4°C.[5]

5) Following phlebotomy for autotransfusion, patients usually go to surgery with a decreased hematocrit. This pre-op hemodilution may actually be beneficial, as it decreases the blood viscosity, thus decreasing peripheral vascular resistance and allowing an increased flow to various organs at the same perfusion pressure.[8]

Unfortunately autotransfusions do not benefit the patient financially as far as laboratory processing charges are concerned, as the units must still be crossmatched prior to reinfusion in order to meet AABB standards. The patient is, however, saved the inconvenience of either having the unit replaced or being required to pay for it.

Jehovah's witnesses' beliefs that forbid the use of homologous transfusions extend to the use of autologous units, which can therefore not be used for members of that faith who are to undergo elective surgery and may require blood replacement.

Because in POCS, the units are collected in ACD and often are stored for up to 21 days, the problems of gradual accumulation of toxic substances due to RBC breakdown and metabolism, the development of an acidic environment in the stored blood, the loss of functional white blood cells, platelets, and clotting factors; and the formation of small microaggregates of degenerating platelets, granulocytes, and fibrin (which may increase pulmonary vascular resistance and decrease effective pulmonary compliance) are problems associated with POCS units as well as with homologous stored blood.[5,9]

In conclusion, the use of POCS at KFH has shown that autologous blood infusion can be a safe and effective way of meeting the ever increasing demand for blood.

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Hemoglobin G Waimanalo Beta Thalassemia

THERESIA G.H. TAN, M.D.*, ROBERT T.S. JIM, M.D.** *and* R. QUENTIN BLACKWELL, Ph.D.***, *Honolulu*

• *Members of a family of pure Filipino ancestry, living on the island of Oahu, Hawaii, were found to possess an unusual combination of beta thalassemia trait and hemoglobin G Waimanalo. A homozygous beta thalassemia is present in one of the offspring. Related case studies point to the need for thorough evaluation of anemia among economically disadvantaged patients, lest iron deficiency be erroneously assumed to be the cause. Transfusions started early in life in a homozygous beta thalassemia have contributed to subsequent normal growth and development, and minimal bone abnormality. Family counseling is deemed an essential component in responsible patient care.*

Hemoglobin G is known to have many variants, dependent upon the localization of the structural change in the alpha-chain.[1,2] Hemoglobin G Waimanalo is characterized by a change in the alpha-64 position of Asparatayl—Asparaginyl beta-2 amino acid.[3] The heterozygous state of hemoglobin G is usually asymptomatic and does not cause anemia.[3] Previous case reports of the combination of Hemoglobin G Philadelphia and alpha thalassemia documented that the patients were asymptomatic, except for red cell abnormalities.[4]

This report provides information on a family, most members of which have mild anemia without clinical symptoms but with morphologic abnormalities of the red cells. One family member, however, exhibits hepatosplenomegaly, skull X-ray changes and severe anemia requiring frequent packed red cell transfusions.

CASE REPORT:

The proposita, N.L., a female baby of Filipino ancestry born in 1972, was first seen at the age of 5½ months. The pregnancy was uneventful, except for anemia which was treated with an iron preparation. No studies of the anemia were done. The child was born by normal spontaneous delivery, weighed 2750 grams and measured 47½ cm. The Apgar Score was 6 after 1 minute and 9 after 5 minutes. She was breastfed. The infant was discharged from the nursery after 3 days.

At age 7 days she was seen at the Hawaii State Department of Health, Waimanalo Children and Youth Project for routine evaluation. A right conjunctivitis was the only noted abnormality. Subsequent routine examinations at 2 and 6 weeks of age revealed a normal breastfed infant. At 10 weeks she was described as "pale" and Fer-in-sol was prescribed in daily doses of 0.6 ml. Blood studies were not performed. No dietary history was taken. At 5 months, the infant was alert and active with unremarkable physical findings, except for pallor. Neither liver nor spleen were palpable. The hemoglobin was 9.0 grams. As the child was receiving only breast milk, the mother was advised to introduce solid foods. Iron therapy was continued and the dose doubled to 1.2 ml. daily. Determinations of serum iron and iron binding capacity were not possible at that time.

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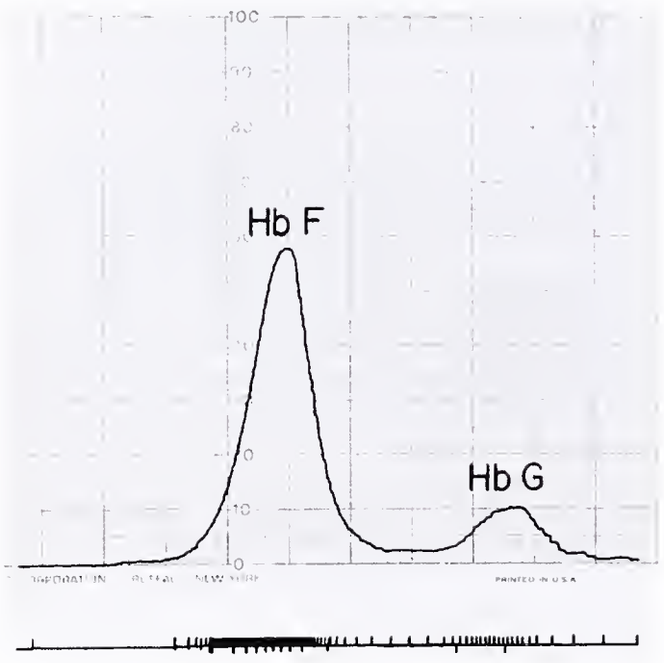
Reprints—Theresia G.H. Tan, M.D., Punawai Clinic, 94-235 Leoku Street, Waipahu, Hawaii 96797. Telephone (808) 671-5706.

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When seen again at age 6½ months, the mother stated that her child was irritable, had lost her appetite, refused solid foods and had difficulty sleeping at night. The infant had marked pallor. The pulse rate was 160 at rest and respirations were 34 per minute. Rectal temperature was 36° C. The liver was palpable 2 cm. below the right costal margin; the spleen was not enlarged.

Blood studies on admission to Kauikeolani Children's Hospital revealed: Group 0, Rh negative blood; Hemoglobin 7.1 grams; hematocrit 21; MCV 77; MCHC 33.5; MCH 26. WBC 16,500/c mm with 2 stabs, 25 segs, 64 lymphs, 7 monos and 2 eos. A reticuocyte count was 5.6; platelets were 240,000/c mm. Blood smear revealed target cells, tear drop cells, nucleated red cells, spherocytes, anisocytosis, poikilocytosis, and polychromasia. Serum iron was 176 mcg (N. 65-175 mcg), TIBC 225 mcg (N. 252-410 mcg), Saturation 76. Total bilirubin 1.3 mg, indirect 0.8 mg, total protein 5.6 mg, albumin 3.3 mg, alpha-1 0.2 mg, alpha-2 0.6 mg, beta 0.6 mg, gamma 0.8 mg. Sickle cell test was negative, although hemoglobin electrophoresis showed an abnormal hemoglobin pattern in the area of hemoglobin S. (Fig. 1)

Fig. 1.—*Hemoglobin electrophoresis of the child in this case.*



Since no facilities were available in Honolulu to determine the nature of this abnormal hemoglobin, a sample of blood was sent to Taipeh to Dr. R. Q. Blackwell's laboratory. The abnormality was defined as Hemoglobin G Waimanalo.

The child received her first transfusion of packed cells at 10 ml/kg bodyweight during the first hospital stay because the hemoglobin had dropped to 6 gm, perhaps due to blood needed for laboratory studies. Response to transfusion was remarkable in that she became a pleasant baby with good appetite, and she slept well.

Every 4 to 8 weeks thereafter, she required transfusions of packed red cells, because of recurrent anemia with hemoglobins ranging from 5 to 6 gm, and symptoms of restlessness, listlessness, irritability, loss of appetite and insomnia.

During her first year of life, the liver and spleen were noted to increase in size, reaching 5 and 3 cm respectively, below the costal margins. Skull X-ray at 6½ months of age showed thickening of the diploe and enlargement of the maxillae. The changes were still minimal at the age of 3 years. (Fig. 2, Fig. 3)

Fig. 2.—*Anteroposterior view skull x-ray of proposita at 3 years of age.*



By age 3, the patient had received 20 transfusions of packed red cells. Her growth and development were falling within normal limits on the Denver Development Scale, and she was attending preschool with normal performance.

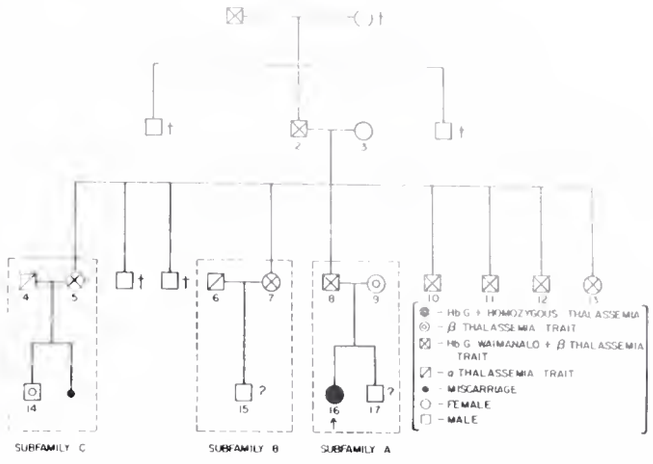
Discussion

During the first hospital admission of this child in 1972, communication with Dr. R. T. S. Jim revealed that he had seen and treated an adult male patient of the same surname 2 years earlier. For that reason, a family study was begun. Doctor Jim's patient was the great-grandfather of the baby described. Other paternal members showed

FIG. 3.—*Lateral view skull x-ray of proposita at 3 years of age.*



FIG. 4.—*Family pedigree showing the dominant inheritance of hemoglobin pathology in 4 generations.*



hemoglobin G Waimanalo by hemoglobin electrophoresis, combined with a beta thalassemia trait.[3] The family pedigree is shown in (Fig. 4) and Hematological studies on (Table 1, Table 2).

Except for patient N.L., paternal members of the family were clinically asymptomatic, showing only mild or no anemia. Hemoglobin electrophoresis on each confirmed the presence of a slow moving hemoglobin G, in addition to normal adult hemoglobin.[3] Elevated hemoglobin A_2 and/or elevated hemoglobin F were noted in all members except the patient's paternal grandmother (#3), who is the only member entirely free of abnormal hemoglobin. Red cell abnormalities were seen in all except two members (#15 and #17).

The patient's mother (#9) has heterozygous beta thalassemia, as confirmed by elevated hemoglobin A_2 of 7.0% (N. 1.8-3.5%) and elevated hemoglobin F of 2.5% (N. less than 2%). The mother's blood smear revealed anisocytosis, poikilocytosis, microcytosis, hypochromasia, target cells, ovalocytosis, and teardrop cells.

N.L.'s father (#8), has the heterozygous form of hemoglobin G disease.[3] Hemoglobin G disease of this type usually does not cause clinical anemia or abnormal red cell morphology.[1] As the father's hemoglobin electrophoresis documented an elevated hemoglobin F (2.3%) and the blood smear revealed red cell abnormalities, his anemia probably results from the presence of a beta thalassemia trait.[1]

The severe disease encountered in patient N.L. probably occurred because of the combination of heterozygous hemoglobin G disease with

TABLE 1.—*Values of hemogram, serum iron and iron binding capacity of the family.*

	SEX	AGE IN YEARS	HB GM% (N: M-16±2) (N: F-14±2)	HCT % (N: M-47±5) (N: F-42±5)	RBC 10^6/MM^3 (N: M-5.4±0.8) (N: F-4.8±0.6)	MCV μ^3 (N 87±5)	MCH $\mu\mu$G (N 29±2)	MCHC % (N: 34±2)	RETICULOCYTE % (N 0.5-1.0%)	SERUM FE MCG% (N: 65-175 MCG%)	TIBC MCG%
1	M	75	11.6	35.9	5.32	67	21.7	32.3	4.3	136	263
2	M	52	12.9	37.0	4.39	84	29.3	34.8	2.1	212	290
3	F	47	12.1	35.6	3.87	91	31.1	33.9	1.6	126	260
4	M	32	13.9	44.5	5.44	63	20.4	32.3	1.9	66.8	235
5	F	28	11.1	34.3	5.52	70	21.5	34.5	2.2	65	253
6	M	30	13.5	42.1	6.89	61	19.7	32.3	1.0	105	244
7	F	21	12.2	41.1	5.45	75	22.2	29.4	1.0	190	331
8	M	23	12.1	37.3	5.74	65	20.9	32.2	2.0	192	258
9	F	23	11.3	35.3	4.55	77	24.7	31.9	2.0	204	407
10	M	18	12.5	37.7	6.05	62	20.6	33.1	0.7	138	300
11	M	14	13.2	43	5.71	75	23.1	30.6	1.0	196	169
12	M	12	10.5	31.7	5.23	61	19.9	32.8	1.0	96	267
13	F	4	10.9	33.9	6.05	55	17.9	31.9	1.0	142	272
14	M	5	11.9	35.5	6.00	50	20.0	33.5	1.4	75	400
15	M	2 mo.	14.7	46.7	4.47	104	32.7	31.3	2.8	—	—
16	F	3	7.1	2.1	2.77	80	24.5	31.5	10.0	176	225
17	M	1 day	13.5	39.9	3.99	99	33.7	33.9	2.5	—	—

TABLE 2.—*Values of hemoglobin electrophoresis and bloodsmear of the family.*

	SEX	HB A %	HB A_2 % (N 1.8-3.5%)	HB G %	HB F % (N < 2%)	ANISOCYTOSIS	POIKILOCYTOSIS	MICROCYTOSIS	HYPOCHROMASIA	TARGET CELLS	OVALOCYTOSIS
1	M	72.9	3.3	21.2	2.6	+	+	+	+	+	
2	M	70.2	5.5	22.5	1.6			+	+		
3	F	96	2.8	0	1.2						
4	M	96.1	2.0	0	1.9		+	+	+		
5	F	69.4	3.1	22.7	4.8	+	+	+	+		+
6	M	94.9	3.4	0	1.7	+	+	+	+		
7	F	69.8	6.8	19.3	4.1		+	+	+	+	
8	M	79.5	3.1	15.1	2.3		+	+	+	+	
9	F	90.5	7.0	0	2.5	++	++	+		+	+
10	M	66.4	2.6	28.5	2.5		+	+	+	+	
11	M	71.8	5.5	19	3.7		+	+	+	+	
12	M	72.7	3.9	18.8	4.6		+	+	+		+
13	F	66.6	7.1	21.8	4.5	+	+	+	+	+	+
14	M	86.9	9.3	0	3.8	+	+	+	+		
15	M	0	0	26.4	73.6						
16	F	0	0	18	82	+	+	+	+	+	
17	M	35	0	0	65						

beta thalassemia from the father and beta thalassemia trait from the mother, the combined inheritance resulting in hemoglobin G disease—homozygous beta thalassemia.

The newborn baby brother of the proposita (#17), when cordblood was studied, had a hemoglobin in the low normal range (13.5 gm%). Hemoglobin electrophoresis revealed 35% hemoglobin A_0 and 65% hemoglobin F, in contrast to his sister, in whom adult hemoglobin was completely absent at the age of 6½ months. Repeat studies of the blood during the first year of life would be necessary to confirm the subsequent outcome and possible presence of a hemoglobinopathy. The newborn infant (#15) in sub-family B, had a low hemoglobin at 1 week of age. His electrophoresis revealed no hemoglobin A_0, but consisted of 73.6% hemoglobin F and 26.4% of a slow moving hemoglobin, the nature of which is now being determined. Several repeat hemoglobin electrophoresis will also be required.

In sub-family C, #14 had beta thalassemia trait, apparently inherited from his mother (#5). His father (#4), however, exhibited an alpha thalassemia trait, as evidenced by a low MCV (71), normal hemoglobin A_2 and F, and microcytosis, poikilocytosis, and polychromasia of his red cells.[5]

The study of this family stresses the importance of the following factors:

1. Anemia found in economically disadvantaged patients is usually assumed to be caused by iron deficiency. On this assumption alone, iron therapy is usually instituted without adequate evaluation of the cause of the anemia and without consideration of the fact that this heavy metal is contraindicated in the treatment of thalassemia.[6]
2. Early diagnosis and treatment of homozygous thalassemia resulted in normal growth and development of the patient described above, as measured by the Denver Development Screening test. Bone abnormalities remained minimal, a finding in agreement with that of Weatherall.[6,7]
3. The impact of diagnosis of a hereditary disease in this family consisted of an emotional upheaval of anger and disbelief. Hostile feelings were directed toward the physician and feelings of guilt and shame bothered the family members. In addition to an understanding of the family's cultural background and their reaction to an emotional-laden diagnosis, the physician in charge had to spend much time in preliminary explanation and subsequent repeated family counseling. This phase of patient care can be facilitated in collaboration with a social worker, fully informed regarding the disease and who establishes good rapport with the family.

 Genetic counseling is needed to prevent the occurrence of the homozygous state of thalassemia, as is a careful and repeated explanation regarding blood transfusion treatment and expected complications of the disease and therapy.[8,9]
4. The intrauterine diagnosis of a hemoglobinopathy is now possible in special centers.[10,11,12,13] It is performed by aspiration of fetal blood sample from the placenta after visualization of its location by ultrasound.[14] The results are encouraging;

in a few years this diagnostic tool may become widely available to prospective parents faced with the risk of a child with severe hemoglobinopathy.

Methods

Blood samples from all the family members were collected by venipuncture in acid-citrate-dextrose solution and sent to Taipeh, where Dr. R.Q. Blackwell *et al* employed special methods to determine the presence of the slow-moving Hb G Waimanalo.[3]

Blood samples were also drawn and cellulose-acetate hemoglobin electrophoresis was performed at pH. 8.6 noting the presence or absence of HbA_2 and/or Hb F. HbA_2 concentrations were determined by elution and Hb F concentrations were determined by alkali denaturation.

Hemograms were performed on a Coulter Model S. RBC morphology was reviewed on Wright stained smears and reticulocytes counted by using New Methylene Blue stain.

Serum iron and iron binding capacity were measured by standard methods.

Abbreviations used.

Hb	hemoglobin
Hct	hematocrit
RBC	red blood cell
MCV	mean corpuscular volume
MCH	mean corpuscular hemoglobin
MCHC	mean corpuscular hemoglobin concentration
Serum Fe	serum iron
TIBC	total iron binding capacity

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JON WON

HMA Nominating Committee met to receive nominations for the officers of the Hawaii Medical Association that are to be elected by the HMA House of Delegates at its Annual Meeting, October 1-6, 1978. The Nominating Committee will submit to the HMA House of Delegates the following slate of nominees:

President-elect:
Douglas B. Bell, II, M.D.
Secretary:
Calvin C. M. Kam, M.D.
Neal E. Winn, M.D.
Alternate AMA Delegate:
William E. Iaconetti, M.D.
Councillor from Kauai:
Thatcher Magoun, M.D.
Councillors from Honolulu:
Nadine C. Bruce, M.D.
Thomas G. Cahill, M.D.
Bernard W. D. Fong, M.D.
Philip I. McNamee, M.D.

All nominees have agreed to serve, if elected. This report is submitted by Dr. Herbert Y. H. Chinn, Chairman, 1978 HMA Nominating Committee.

Three Medical Families Have Filed to run for election to the Hawaii State Legislature in 1978. Dr. Richard Ando is running on the Democratic ticket as a senatorial candidate in the 6th Senatorial District which includes Manoa, Makiki, Moiliili, McCully, Tantalus, Waikiki, Kakaako, Sheridan, and Downtown Honolulu. Patricia Saiki, spouse of Dr. Stanley Saiki, is running for re-election as a Republican senatorial candidate in the 7th Senatorial District which includes the area from Diamond Head to Makapuu Point. Faith P. Evans, RN, has filed for re-election as a Republican representative candidate in the 24th Representative District of Windward Oahu. All physicians and their spouses are encouraged to provide support and vote for the candidates of their choice. Primary Election will be on Saturday, October 7, 1978; General Election on Tuesday, November 7, 1978.

Reminder, Reminder, Reminder to all Chairmen of HMA Committees, Commissions, and Boards, that the annual report of your body needs to be in in plenty of time for the HMA Annual Meeting, Oct. 1-6. More information will be forthcoming soon, but these reports need to be turned in as soon as possible so that they can be reproduced for inclusion into the HMA House of Delegates Handbooks.

California Medical Association has voted to support another countersuit, this one attacking a baseless lawsuit against a Southern California physician. In that suit, the plaintiff's attorney failed to conduct discovery proceeding, did not present expert testimony, and apparently waited until trial time to contact a crucial witness who denied there was any basis for liability.

Retired Physicians or physicians about to retire may be interested in joining the American Retired Physicians Association. This AMA-endorsed, independent organization was founded three years ago to help retiring and retired physicians and their spouses. For information, write ARPA, 536 No. State Street, Chicago, Illinois 60610. Phone (312) 751-6469.

President Carter Recently Announced his principles for a national health plan. For your information, these principles are:

" 1. The plan should assure that all Americans have comprehensive health care coverage, including protection against catastrophic medical expenses.
2. The plan should make quality health care available to all Americans. It should seek to eliminate those aspects of the current health system that often cause the poor to receive substandard care.
3. The plan should assure that all Americans have freedom of choice in the selection of physicians, hospitals, and health delivery systems.
4. The plan must support our efforts to control inflation in the economy by reducing unnecessary health care spending. The plan should include aggressive cost containment measures and should also strengthen competitive forces in the health care sector.

5. The plan should be designed so that additional public and private expenditures for improved health benefits and coverage will be substantially offset by savings from greater efficiency in the health care system.
6. The plan will involve no additional federal spending until FY 1983, because of tight fiscal constraints and the need for careful planning and implementation. Thereafter, the plan should be phased in gradually. As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other government programs, in which expenditures far exceeded initial projections, must not be repeated.
7. The plan should be financed through multiple sources, including government funding and contributions from employers and employees. Careful consideration should be given to the other demands on government budgets, the existing tax burdens on the American people, and the ability of many consumers to share a moderate portion of the cost of their care.
8. The plan should include a significant role for the private insurance industry, with appropriate government regulation.
9. The plan should provide resources and develop payment methods to promote such major reforms in delivering health care services as substantially increasing the availability of ambulatory and preventive services, attracting personnel to underserved rural and urban areas, and encouraging the use of prepaid health plans.
10. The plan should assure consumer representation throughout its operation."

In Presenting The NHI Principles, DHEW Secretary Califano told the press that health care costs are still rising, exceeding the general cost of living. Yet only a day earlier, the Bureau of Labor Statistics had released Consumer Price Index Figures showing a medical care increase of 0.5% in June, while the all-items index rose by 1.0%. The medical care index increased 0.6% in April and May, but the all-items index rose 0.9% in both months.

Physicians' Medicare Reimbursement Rates were increased by 5%, effective retroactively to July 1. The action, estimated to cost $1.1 billion over the next 12 months, follows an annual cost of living review by the DHEW. The new fee structure will allow Medicare to pay 5.08% more than is currently allowed for certain medical procedures in different areas.

Physicians Who "Routinely" Waive collection of coinsurance or deductibles from Medicare patients may find their actual and customary charges *reduced* by carriers. According to Section 5220 of HEW's Part B Medicare Carriers Manual, carriers are instructed to review such cases and process claims on the basis of the amounts the physicians actually expect to receive. These amounts will be used in updating customary charge screens. Exceptions will be made when the waiver is because of "a particular patient's straitened circumstances" or when the cost of billing for and collecting the coinsurance would be out of proportion to the amount owed. Carriers are expected to put the directive into effect shortly.

The Nation Got a Peek at Government-run Medicine when the General Accounting Office reported to Congress on the 112 neighborhood health centers operated by HEW. This relatively small ($200 million) program seems to be afflicted with obesity, maldistribution, high cost, waste, and failure to emphasize preventive medicine.

Although HEW estimates that 45 million Americans lack adequate access to health care, the GAO pointed out, HEW's own centers are generally overstaffed and underused. Many of the centers are in the wrong locations, the report said, and many of the people have other sources of health care.

HEW has a minimum standard of 2.7 patients per hour for physicians at community health centers, the GAO noted, but at 58% of the centers the average fell below the standard. Annual salary costs for excess primary care physicians is above $4 million and the cost for excess supporting staff is $6.3 million, the report said.

"The people to whom the health center program is targeted appear to use the center to cure today's sickness rather than prevent tomorrow's," the report commented. The GAO had this suggestion for HEW—promote preventive health care services.

Available approximately Nov. 1, 1978, will be time-share use of a new medical suite in the new Aiea Medical Building. Suite consists of office, two exam rooms and an office procedure room suitable for various endoscopies or office surgical procedures. Interested physicians contact Lee Simmons, M.D. at 533-3661.

Wanted: Surgeon/Administrator/Coordinator Emergency Services. Minimum: 4 yrs. surgical residency with board Certificate, 10 yrs. surgery and 5 yrs. administration experience. Does 40% general surgery, 35% administration in assisting medical director of company in determining medical policies and supervising 11 employees, 25% coordinating, training, planning, implementing disaster control program. Salary - $52,000 per year. Contact Bonnie at Airport Medical Services, Phone 949-6121.

"Enhancing Your Financial Skills" for physicians, a special one-day seminar, will be presented on Sunday October 1, 1978 at the Ilikai Hotel. This program is presented by HMA as a Special Event in conjunction with the AMA Regional Continuing Medical Education Program. It is specially designed to give physicians and their spouses the tools they need to make more informed financial decisions. Specialists in practice management, investments, insurance and estate planning will discuss the fundamentals of building a strong financial program. Presentations focus on areas common to physicians including appropriate investments for retirement plans and personal funds.

The faculty will include Jack Walsdorf, a program specialist in the Department of Practice Management of the AMA. Prior to joining the AMA, Mr. Walsdorf was responsible for the practice management activities of the American Dental Association and served as a financial management consultant for physicians and dentists in the Chicago area. A local member of the faculty will be Attorney Elliot "Buzz" Loden, a director in the law firm of Torkildson, Katz, Jossem & Loden, who was formerly an IRS attorney and estate tax reviewer. He is President-Elect, Section of Taxation, Hawaii Bar Association; an instructor, University of Hawaii, Law for the Small Businessman and Law for the Non-Lawyer; instructor, American Institute of Certified Public Accountants; and a lecturer for the Hawaii State Real Estate Education Conference and American College of Clinic Managers.

What makes this program so special is that the experts are not selling anything. Their function is to advise you on the essentials of sound financial and estate planning.

Seminar materials are provided to allow physicians to construct a money-management plan to suit their needs. Spouses are strongly encouraged to attend with their physician sponsors. The fees are $75 for physician attendee. There is no additional registration fee for spouses attending with their physician sponsor. Lunch is included. Six hours of Category II credit will be given.

This all-day 9 a.m. to 4 p.m. meeting will be held in the Hilo Suite of the Ilikai Hotel. Registration forms are being mailed to physician members of HMA during August. For additional information concerning registration for this seminar contact Bess Chang at the Hawaii Medical Association, telephone 536-7702.



The role of a modern family physician

In England, the patient goes to a general practitioner first.

In America (USA) the patient often makes his own diagnosis and then picks what he thinks is an appropriate specialist. This is conducive to the type of medical care that is organ- or systems-oriented, that tends to ignore the patient as a whole body or person, and that is the most expensive way to go. This is a high-cost item and it is patient-induced.

The generalist often sees patients who casually tell him that they see their Ob/Gyn doctor for periodic "complete physicals," which are, in fact, no more than a breast check and a pelvic exam with PAP smear. An example in point appears in the July No. 2 Newsletter of Citizens for the Treatment of High Blood Pressure, Inc. It cites a two year 1975 and 1976 study in which a little less than 60% of patient-visits to Ob/Gyn specialists included the taking of the blood pressure—this in a specialty that deals in large measure with toxemia of pregnancy or threat thereof. (However, in this same study, those physicians in general or family practice did even worse—41.3%! And, the specialists in cardiovascular diseases, who should be and are at the top of the scale, came up with only 71.6% application of the sphygmo to the arm!)

That same generalist's patient may also have an attending allergist for her hay-fever, an otolaryngologist for her Meniere's and maybe a proctologist for her hemorrhoids or an orthopedist for her lumbago. "Too many cooks can spoil the soup" is an apt axiom based on long-time observation. In terms of medical care, the implications of serious adverse effects of in-

teracting drugs can be a large factor in that patient's total well-being, as the several physicians perhaps prescribe drugs with no knowledge of their colleagues' prescriptions to the same patient, particularly if the latter withholds the information deliberately, as so many of them do. Many a patient under the care of a psychiatrist and taking psychotropic drugs, does not reveal that fact to an internist, surgeon, or even a generalist. Many a woman on hormones, or on the contraceptive pill, does not reveal that information spontaneously when she goes to see another physician for her hypertension.

In England, the system—a specialist can be seen only on referral from a GP—not only tends to keep specialist, ie, expensive care within reasonable limits, but it also makes for a more holistic approach to the patient's problem.

Here in this country, the question of "a second opinion" in surgery, for example, may be resolved in large measure if surgeons insisted that the patient who came in for an elective procedure return with a complete history and physical and an evaluation or "clearance" from the family physician of record or of choice, *prior* to scheduling that surgery. Many surgeons, particularly in the subspecialties, do this as their routine. The involved family physician appreciates this request as an attempt at team care of the whole person. The patient also is assured of better and of more unbiased care in the sense that his concern over the surgeon's being perhaps too dedicated to his art, not to say overzealous, as being prejudicial to the patient's best interest.

The general public should be educated to the realization that such an approach to health care—to go through a primary care physician first—will net the patient a more whole-person response to the problem of his illness, and that it may well reduce the costs overall.

The modern-day physician trained in family practice may not be able to exercise more than the simplest of surgical, obstetrical, pediatric and intensive medical privileges in hospitals, but he is trained well to be a medical manager, advisor and team-care leader for the patient and his family, and, therefore, invaluable in the event of a medical crisis.

J.I.F.R.

Hemoglobin G article

In this issue appears a family study of a hemoglobinopathy.

Whereas some families might regard such an occurrence as an act of God or a phenomenon of nature (depending on their persuasion), the family described herein expressed hostility toward the physician(s) for discovering their inborn error, and, alternately, "anger, disbelief—guilt and shame—."

Anger toward the physician for discovering a disease or disorder certainly does not come as a surprise to any clinician who has handed a patient a new diagnosis. This is something we all must deal with, who are on the "firing line" of clinical practice.

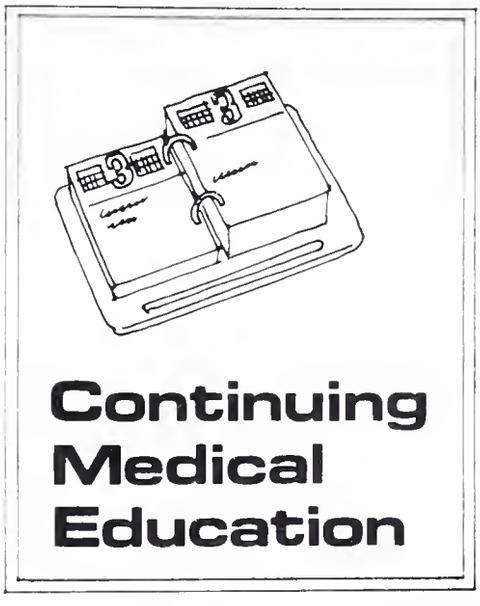
Guilt and shame and anger for "bad" genes, expressed among members of a family, can tear that family apart.

Surely, herein lies the need for the physician's art—to deal with such feelings and to help the family to deal with them.

Genetic counselling in such a case is an important part of the care of the family.

Fortunately, facilities and personnel, through our Children's Hospital and the University of Hawaii's School of Medicine, are becoming more available in this community—to provide genetic counselling, and to help families feel less guilty and angry for being less than perfect.

DORIS R. JASINSKI M.D.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:15 p.m. & 3rd Tues. w/ Maui Mem. Hsp. 12:30 p.m.

John A. Burns School of Medicine

1. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
2. U.H. Cardiology Grnd. Rnds., 1st Tues. 5:30 p.m. Rm. 506 Univ. Tower, Queen's.
3. UH Grand Rnds-Ob/Gyn, Wed. 7:30-8:30 a.m. Kapiolani Hsp. Aud.
4. UH Perinatal Conf., Thurs. 3:30-4:30 p.m. Kapiolani Hsp. Rm. 815.
5. UH Seminar, 2:30-3:30 p.m. Kapiolani Hsp. Rm. 826. Fridays, 1st-Pathology; 2nd-Perinatology; 4th-Journal Club.
6. UH Conf., Friday, 3:30-4:40 p.m. Kapiolani Rm. 826.
7. UH Visiting Prof. Program for Ob-Gyn, Quarterly.

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Kapiolani Maternity Hospital

1. Tuesday Conference, 1:00-2:00 p.m. Kapiolani Hsp. Aud.
 1st—Didactic Presentation
 2nd—Perinatal-Neonatal Topics
 3rd—Obstetrics Topics
 4th—Gyn Topics
2. Neonatal Grand Rnds., Friday 8:00-9:00 a.m. Kapiolani Hsp. Nursery.
3. Tumor Board-Oncology Conf., 1st & 3rd Friday, 1:00-2:00 p.m. Kapiolani Hsp. Aud.

Kuakini Medical Center

1. Visiting Professor Programs
2. G.I. Conf., 3rd or 4th Tues, 8:00-9:00 a.m.
3. Ophthalmology Departmental Mtg., 2nd Tues. 1:00-2:00 p.m.
4. Medical Mortality & Morbidity Conf. (Dept. of Med. Mtg.) 4th Tues. ea. month, 1:00-2:00 p.m.
5. Nephrology Conf., 4th Wed., 8:00-9:00 a.m.
6. Oncology Conf., ea. Thurs. 7:30-8:30 a.m.
7. Surgical Conf., Friday, 1:00-2:00 p.m.
8. Surgical Mortality & Morbidity Conf. (Dept. of Surg. Mtg.), 4th Friday, 1:00-2:00 p.m.)

(Contact CME Dept.-Kuakini for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
6. SFH-UH Surg. Sat. Teaching Rnds. (except 4th) 7:30-8:30 a.m. UH 4 Classroom.
7. SFH-UH Hematology Conf., 4th Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
8. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
9. Tumor Conf., ea. Monday, 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Cardiac Surgery Meeting meets the 2nd Tuesday of the month, from 4:30-5:30 p.m. in the Doctor's Dining Room.
3. Friday Noon Conference meets weekly, from 12:30-1:30 p.m., in the Doctor's Dining Room.
4. Medical Grand Rounds meets the 1st Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.
5. Orthopedic Conference meets quarterly, from 7:30-9:00 p.m., in the Doctor's Dining Room.
6. Quarterly Professional Meeting meets the 4th Monday of the month, from 7:30-8:30 p.m., in the Doctor's Dining Room.
7. Surgical Mortality and Morbidity meets the 4th Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Local Hospitals, Honolulu
Type: I, 1 hr./day, 1 day/mo. from 12 mos.
Fee: None Methods: AV, O, Pan
Dates: All yr., 12 hrs. instruction

SPECIAL EVENTS

August 26-Sept. 4, 1978	Post Grad. Education for Professionals—U of C Schl. of Med. Held at Mauna Kea Beach Htl. Contact: Barry S. Ramer, M.D., Director, U of C Schl. of Med. Calif. 18 hrs. Cat. 1.

Sept. 19, 1978	HI Heart Assoc./HMA-Seminar/Workshop—Stroke. 1:30-9:30 p.m. Tues. Ala Moana Americana Htl. 7½ hrs. Cat. I. Chairman: Jordon Popper, M.D.
Sept. 20-23, 1978	Genetics & the Pediatrician—What Every Ped. Should Know.—Held on Oahu & Maui. Contact: Wilma Schiner, Workshop Coord. Kapiolani-Chldrn's Hsp. 1319 Punahou St., Honolulu, HI 96826 for further info.
Sept. 24-26, 1978	Med. Mycology Workshop, Hi. Soc. for Med. Technology/HMA. Ala Moana Htl., Americana Rm., Honolulu. 10 hrs. Cat. I. Contact: Wayne S. Haraga, 2066 Palolo Ave., Honolulu 96816.
Sept. 28-Oct. 7, 1978	Am. Acad. of Family Phys. 1978 Invitational Scientific Congress. Roger Tusken, Exec. Dir. 1740 West 92nd St., Kansas City, MO 64114. Held at Maui Surf Htl.
Oct. 1, 6, 1978	122nd HMA Annual Mtg. & AMA Regional CME Mtg. Ilikai Htl. Ala Moana Blvd., Honolulu. Contact: Mrs. Bess Chang at HMA for further info.
Oct. 2-6, 1978	Western Dialysis & Transplant Soc. Held at Hilton Hawaiian Village, Honolulu. 12 hrs. Cat. I. Contact: Arnold Siemsen, M.D., General Program Chairman, (808) 547-6522.
Oct. 8, 14, 1978	Am. College of OB/GYN. Held at Sheraton Waikiki/Kauai/Maui/Kona Surf. Cat. I. Contact: Wm. Hindle, M.D. 888 So. King St., Honolulu 96813, Ph. (808) 523-2311.
Oct. 8, 21, 1978	Tutor Ongologist, Byrl J. Kennedy, M.D., U of Minn. At all major hsp. on Oahu and neighbor islands. 1 hr. Cat. I. Contact: Am. Cancer Soc. Hi Div. (808) 536-2031 or check with your local hsp. for time.

PERSONNEL-ITY OF THE PACIFIC

"We Bring People Together"

Dear Doctor:

Just the other day, two physicians and I entered into a rather heated discussion as to why they never use a personnel placement service. The discussion went something like this:

Agencies send anyone and everyone in their files without knowledge or consideration as to experience in our particular field.
We spend hours of wasted time interviewing needlessly.
The agency is interested only in a fee, not our needs.

Apparently, they have cause to feel as they do.

As to a fee -- yes, as you charge a fee for service, so must we. However, our fee is set by State regulation. If you choose to pay the fee, that is between you and the apolicant; otherwise, the applicant is responsible for the fee.

In summation, just let me say that it is apparent that the physicians have a point; therefore, we offer the following:

We will act as your personnel administrator.
We will advertise for your specific needs.
We will prescreen, test, and interview prospective employees, reducing the time you spend with an applicant to a final interview in your office.

Our professionally trained staff requests that we be allowed to serve your needs. Allow us the opportunity to prove that we can and will meet your specific needs.

Sincerely,

Paul S. Isenburg, Ph.D.
Director
Medical Division

1441 Kapiolani Blvd./Suite 1203, Honolulu, Hawaii 96814/Phone 955-6686

OUT OF STATE

For information on any out of state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.

Hawaii Academy of Family Physicians' Newsletter

J. L. Frederick Reppun, M.D.

New Members—Catalino Cachero MD has been elected to Active membership by action of the Council on the basis of his submitting 150 hours of approved credit hours the past three years. Welcome back!

Members Dropped—David Miyauchi UHSM '80, **Clarice Sackett** UHSM '79; **James Y.S. Tom MD** '78, whose current whereabouts are unknown; **Stephen L. Wee** UHSM '80. All of these are or were Student members.

News of Members—Other graduates of UHSM and receiving their MD degrees in June include: **Peter B. Barnett** who has gone into Internal Medicine in Tucson, Arizona, **Jeff Baysa** to Albuquerque, NM in Pediatrics, **Lloyd T. Kobayashi** into the FP Residency at Kaiser in Honolulu, **Sandra Penn** to a Residency presumably in FP in Albuquerque, and **Victor Yano** in a Flexible Residency in Tucson. Student member **Kevin Kunz** '79 is off to PR China with a student tour. Active member **Jim Koch** has transferred to Albuquerque (Boy! What an exodus to Albuquerque!). **Peter Leeson D.O.** has moved to Selma, California. **Homer Izumi** has retired from active practice and his office and practice are being taken over by Jinichi Tokeshi MD who, we understand, is a member of AAFP. **David Livingston** has become a Fellow by dint of his receiving the degree in 1977. Former Student member Robert Kranz is back in town as a fully-trained anaesthesiologist.

Iowa Opportunity—The Dept of FP at the Iowa School of Med is looking for faculty; those interested please call Jean.

July Dinner Meeting—was quite successful with probably a record attendance at the Windward home of **Don** and **Marlies Farrell**—58. This included 28 members, of which 8 were students. Al Scottolini MD and Pam Russell RN made interesting presentations for 2 hours of "P" credit; only three—repeat, 3—"yellow cards" were turned in by the members! Members who need "P" credits in pleasant and convivial surroundings should come to these dinners!

Questionnaire—on the details of how you practice medicine is being devised by student **Lily Ning** (who has applied for membership) and will be presented to

the Council for approval; active members are asked to kokua so that UHSM students may get some idea of what they might be up against when it comes to the practice of Family Medicine.

CME—The U of Washington School of Medicine in Seattle has gotten its licks in early for a 4-day seminar at the Hawaii Hyatt Regency Hotel in April 1979: **"Current Concepts in Ob/Gyn"** and has been granted 20 hours of "P" credit. September 8 is the deadline before which those wishing to take the 9-month CORE CONTENT REVIEW 1978-1979 must enroll, for 32 of "P." Remember 25-28 September AAFP Annual Scientific Session in San Francisco, followed by the Invitational on Maui 28 Sept to 5 October. Workshop on "Stroke" 19 Sept has no approved category as yet. Your delegates to the AAFP Congress are **Farrell** and **Lafferty.**



Dear Friends:

Well, it is time once again to renew my subscription to your JOURNAL and give my bit of comment. Enclosed is a check for a renewal subscription. Since there are no rates listed in the mast-head, I am sending the same amount as I did last year.

Why doesn't the JOURNAL publish an index in the December issue? There are some strange physicians (like me) who do save their issues and have them bound for that special reference in the future. Not all of us can afford to subscribe to INDEX MEDICUS. Nor are all of us near a medical library when we need the reference.

At any rate, all of last year's issues were received by me here in the jungle of the upper Amazon Valley, which should say something for office competency in Honolulu. I enjoy the jokes as well as the scientific articles and my opinion is that you continue to improve them BOTH!

Thank you!

THOMAS BROWN, SDB, MD
Medical Director
Centro Medico "San Jose"
Taisha (Morona-Santiago) Ecuador

There should be an index in the December issue and there will be one next December, Doctor Brown. We are working on both the scientific articles and the jokes as you suggest.

Editor





William A. Boyson, M.D.
1356 Lusitana Street
Honolulu, Hawaii 96813
OB-GYN



Carol Ann Brown, M.D.
1356 Lusitana Street
Honolulu, Hawaii 96813
PSYCHIATRY



May 5, 1978, 5:30 p.m.
HMA Conference Room

PRESENT

Drs. Marion Hanlon, George Goto, Calvin C. J. Sia, Douglas Bell II, William Hindle, Herbert Chinn,

George H. Mills, Patrick Walsh, James Williams, Calvin Kam, Arnold Siemsen, Leonard Howard, Alexander Roth, Felix Lafferty, Neal Winn, Denis Fu, Arch Wigle plus Roy Kuboyama, William Dang, Donald Char, Ann Catts, Nadine Bruce and Mrs. Berna Yim.

EXCUSED

Drs. Wm. Iaconetti, Russell Stodd, Rex Couch, Rowlin Lichter, John Edwards, Peter Kim, Phil McNamee.

MINUTES

The minutes of the April 7, 1978 meeting were approved as circulated.

REPORT OF THE SECRETARY

The membership report as of May 1, 1978 indicated that there were 866 members of the HMA, an increase of 44 from the previous month, and 72 members with dues outstanding.

REPORT OF THE TREASURER

The March 1978 financial statement was reviewed in detail.

ACTION:

It was voted to accept the March 1978 financial statement subject to audit.

REPORTS OF THE COMITTEES AND COMMISSIONS

A. Building Committee: Mr. Won reported that the Building Committee met prior to the Council meeting to review the use of HMA property for removal of an adjoining radio tower. A request from the building manager to repair a portion of the roof was also reviewed and the building committee recommends Council approval of the request.

ACTION:

It was voted to proceed with the repair of the roof.

B. Medical Education: Dr. Bruce reviewed the relationship between the Liaison Committee on Continuing Medical Education (LCCME), the AMA, and the HMA and noted that the LCCME is now responsible for the final accreditation of institutions who seek accreditation of their CME programs. She also noted that it was reported recently that the Review Committee of the LCCME recently postponed action on the accreditation of many facilities and pointed out that this could hamper physicians who need to obtain Category 1 credits for relicensure. The HMA CME Committee recommends that a letter expressing these concerns be written to the LCCME and discussed with representatives of the AMA. The Council agreed that a letter be written immediately.

C. Public Affairs: The Public Affairs Committee is presently reviewing the HMA Code of Cooperation. Mr. Won reported that a public relations assistant has been hired and will begin work on June 1. It was also noted that HMA has received preliminary notification that its request for a grant from the Chamber of Commerce was approved.

D. Legislation: Dr. Howard reported that the Legislature passed and sent to the Governor bills which will provide funding for the EMS program, a definition of death, a permanent and statewide School Health Program, a unit for Medicaid fraud and abuse, and some amendments to the modus operandi for the medical claim conciliation panels. He noted his concern that the bill relating to the establishment of a commission on medical, moral and legal concerns did not pass and hoped that the HMA's committee would be able to work out the objections to the bill in the coming months and be prepared to introduce the legislation in the next session.

ACTION:

It was voted to request that HMA's Committee on Medical, Moral, and Legal Concerns meet again and see if they can work out some of the details regarding the establishment of a commission, of a budget, and to explore sources of funding for such a commission.

E. EMS: Dr. Dang reviewed the passage of the legislation relating to the funding of the EMS program. He noted that a party was held to thank everyone who helped the EMS program and asked that Council approve the expenses for this occasion. He also requested that the Council approve an allocation for the graduation party for the MICTs and EMTs.

ACTION:

It was voted to approve the expenditure of $319.00 for the EMS party. It was further voted to approve an expenditure of up to $600 for the graduation party and noted that a line item for graduation expenses should be included in any future budgets.

A bill for legal services was also reviewed by the Council and it was recommended that it be referred to the EMS insurance carrier.

F. Community Health: Dr. Char reported that the final version of the State Health Plan was approved by SHCC and sent to DHEW. He reviewed the actions of the Community Health Committee regarding the proposed Memorandum of Agreement between SHPDA and HMA.

ACTION:

It was voted to refer the proposed Memorandum of Agreement to the proper resources within the HMA for action.

G. Cancer Center: Dr. Hanlon reported that a letter had been sent per the instruction of the Council at its last meeting and that a letter had been received from Dr. Matsuda in response. It was recommended that the HMA remove their support of the present Cancer Center structure.

ACTION:

It was moved, seconded, and passed unanimously that the HMA withdraw its support of and participation in the Cancer Center.

H. Cost Containment: Dr. Mills reported that the steering committee for the Voluntary Effort has been organized and that each hospital has been asked to sign a resolution of cooperation in the Voluntary Effort. He noted the importance for physicians to keep abreast of this effort in their respective hospitals and noted that it is hoped that the rate of increase in expenditures will be reduced by 2% in 1978 and 2% in 1979. HMA representatives on the Voluntary Effort Committee are Dr. Marion Hanlon, Dr. Rodney West, and Mrs. Becky Kendro.

I. Report of the Auxiliary: Mrs. Berna Yim, newly installed president of the HMA Auxiliary, reported that the auxiliary would continue with its goal to assist the HMA in the coming year. She reminded the Council that a communications workshop would be held on May 30 and noted that it was open to all members as well as their office staff.

J. Report of the County Medical Societies: Dr. Wil-

liams reported that they had recently conducted a survey of Hawaii County members regarding unit rule and noted that their county now has less than 50% of its physicians as members. He noted that the county is presently reviewing their charter and bylaws. Dr. Walsh reported that Honolulu County met recently with representatives of the specialty societies and hopes it may be possible to reorganize the county society with representation from these societies.

UNFINISHED BUSINESS

A. Dr. Goto reported that a meeting had been held with representatives of the American Medical Student Association and noted that the students are interested in finding out more about the HMA. He recommended that the Honolulu County Medical Society establish liaison with the students and invite them to participate in society functions.

B. Mabel Smyth Building: Mr. Won reported that the documents to dissolve the tripartite agreement for management of the Mabel Smyth Building were signed by the HNA, Queen's Medical Center and HMA.

NEW BUSINESS

A. Congratulations were extended to Dr. Calvin Sia who was elected by the AAP to represent the Pediatric Section in the House of Delegates of the AMA.

B. County medical society presidents were encouraged to attend the AMA meeting in St. Louis.

ADJOURNMENT

The meeting adjourned at 8:50 p.m.

DOUGLAS B. BELL II, M.D.
Secretary

June 3, 1978, 5:30 p.m.
HMA Conference Room

PRESENT

Drs. Hanlon, Bell, Hindle, Chinn, Iaconetti, Walsh, Stodd, Lichter, Edwards, Siemsen, Roth, Lafferty, Winn, Kim, Wigle and Kuboyama, Dang, Catts, Bruce, Livingston Wong, Chun-Hoon, Nicholson, McCabe, and Char.

EXCUSED

Drs. Goto, Sia, Mills, Williams, Couch, Kam, Howard, Fu.

REPORT OF THE TREASURER

The financial statement for April 1978 was reviewed in detail. A new concise statement of income and expenses and a balance sheet were reviewed and it was agreed that this form of reporting should be continued.

ACTION:
It was voted to approve the April 1978 financial statement subject to audit.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. Legislation: Dr. Siemsen reported that he had attended several meetings since the last Council meeting regarding the bill passed by the State Legislature relating to a definition of death. He noted that the bill had not yet been signed by the Governor. He noted the concerns of the Kauai County Medical Society regarding the bill and reported that all of the concerns of various members of the community were explored in detail. He noted that should the bill be enacted into law, there would be need for some continuing education regarding it.

B. Fee Survey Committee: A copy of a letter from Dr. Chun-Hoon regarding the proposed publication of the Current Procedural Terminology Manual was circulated to the Council. The letter outlined concerns regarding the expense of publishing a document of this nature in light of recent consent decrees filed by the FTC against several state medical associations and national specialty societies who have published relative value studies. Dr. Nicholson, chairman of the Fee Survey Committee, noted that the preface to the proposed CPT Manual clearly states the intent of the book to allow the accurate coding and describing of procedures performed by physicians in their correspondence with various insurance carriers and governmental agencies. The manual is not intended as a fee schedule and does not attempt to regulate the fees charged for any procedure. He also pointed out that the cases currently in court have not yet been settled and that the consent decrees do not include any admission of wrongdoing.

Dr. Michael McCabe, president of the Hawaii Radiological Society, reviewed the experience of the American College of Radiology and the FTC regarding the RVS. Because of the questionable legalities regarding the publication of an RVS, the Hawaii Radiological Society wrote to the HMA and asked that a radiological section not be included in any planned RVS. (A copy of the entire letter is reprinted below.)

The chairman of the Fee Survey Committee noted that they respected the feelings of the Hawaii Radiological Society with regard to participation in the development of any RVS but wanted to include a



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section on radiology for those physicians (non-radiologists) who do x-ray work in their offices.

The members of the Council discussed the possibility of encouraging insurance carriers or an agency of government to publish a procedural manual. This will be explored further. Dr. Nicholson agreed that further clarification was needed regarding the legality of a CPT Manual.

ACTION:

The Council voted to postpone the publication of a Current Procedural Terminology Manual until clarification regarding the legality of the document is established. There were two dissenting votes.

March 21, 1978

To: Fee Survey Committee, HMA

The American College of Radiology has entered into an agreement with Federal Trade Commission that A.C.R. will no longer develop nor promulgate R.V.S. in any form. Regarding the possibility that we include in the R.V.S. publication a radiology section preceded by a disclaimer that we are not including any reference to prices, our lawyers advised us that this could *still* be leading A.C.R. into a potential contempt of court charge, inasmuch as this action could be construed as "aiding and abetting an R.V.S."Because of these questionable legalities requiring further study, the Hawaii Radiological Society voted unanimously at its March 20, 1978 meeting that the Hawaii Medical Association not include a radiological section in the presently planned HMA R.V.S. publication. The unanimous vote included a provision that HMA be constrained from including a radiological section within any R.V.S. publication now or in the future without a letter of authorization from the president of Hawaii Radiological Society.

Sincerely,

MICHAEL J. MCCABE, M.D.
President, Hawaii Radiological Society

C. Public Relations: Mr. Won introduced Mrs. Ceci Young who will serve as public relations specialist to the HMA and HCMS.

D. EMS: Dr. Wong reported that the federal grant period of funding for the EMS program will come to an end on June 30 and that the funds appropriated by the 1978 Legislature will be administered through the Department of Health. He also noted that beginning July 1, the students in the EMT and MICT program will be eligible for college credits for the courses they are enrolled in.

E. Medical Education: Dr. Bruce reported that the CME Committee reviewed the HMA's award for CME at their last meeting which will be known as the Physician's Education Certificate (PEC). She shared the concerns of the CME Committee regarding the return of accreditation forms for two Hawai'i hospitals which were questioned by the Review Committee of the LCCME. It was also noted that the Board of Medical Examiners has mailed a letter to all licensees regarding the requirements for licensure as of January 1, 1980. The letter is not clear regarding the requirements for retirees or with reciprocity between the Board of Medical Examiners' requirements and that of other states or societies. Dr. Bruce reported also that she had met with the Dean of the John A. Burns School of Medicine and they are interested in participating in the HMA's recordkeeping system for CME credits.

Dr. Bruce also noted that there were 548 responses from the HMA membership regarding CME credits: 210 said they had a valid certificate and met the requirements of CME, 84 stated they had sufficient credits but had not made formal application, 47 responded that they will have enough credits to make application by January 1, 1979, 93 replied that they had enough credits but didn't know how to make application for the CME award, 93 didn't have enough credits and did not know how to make application for the award, 10 indicated they were retired. The CME Committee will followup with individual contacts to those having difficulty in understanding the requirements.

Dr. Hanlon noted that inasmuch as the AMA Meeting in St. Louis would devote a portion of its time to CME, he had asked Dr. Nadine Bruce to attend the meeting as alternate AMA Delegate *pro tem.*

F. Community Health: Dr. Felix Lafferty and Mrs. Becky Kendro attended the 9% Solution on Molokai, May 30-June 2, and presented a preliminary report. They noted that approximately 30 persons attended the conference to concentrate on possible ways to curtail the rising spiral of health care costs. The group identified four task forces which will be asked to meet quickly to pursue specific ideas and reconvene in October for an interim report with another meeting in January. HMA physicians will be asked to participate on the task forces.

G. Cancer Center: Copies of correspondence between the HMA and the Cancer Center was reviewed outlining the withdrawal of HMA support and the abolishment of the Cancer Center Executive Committee. Questions were raised regarding HMA's role in the Community Cancer Program and it was agreed that the action of the previous meeting included the CCP and that HMA has no official participation in the Cancer Center; however, participation by individual members is strictly a personal decision.

H. Report of the County Medical Societies: Kauai County noted its concern regarding the definition of death bill and reported that their society is opposed to its passage. Dr. Kim also reported that their society is exploring a mammography project in cooperation with PHRI. Dr. Stodd reported that Maui County voted unanimously to support the definition of death bill. It was also noted for information that the medical staff at Maui Memorial Hospital has voted not to be delegated by PSRO. Hawaii County Society voted to incorporate their society.

UNFINISHED BUSINESS

A. Appraisal Fee: Mr. Won reported that the bill submitted for appraisal of the 320 Ward building was higher than that which was quoted initially.

ACTION:

It was voted to authorize $1300 for the appraisal.

B. Audit fee: The fee for auditing was reviewed.

ACTION:

It was voted to authorize up to $6,000 for the 1978 audit.

C. Actuarial fee: A bill for actuarial expenses for the retirement plan was reviewed by Mr. Won.

ACTION:

It was voted to authorize the payment of $2,600 for actuarial fees.

D. Travel: A letter was reviewed regarding an EMS conference in Chicago.

ACTION:

It was voted to approve travel funds for Dr. Dang to attend the conference.

E. Request from Attorney General: It was noted that the HMA as well as the HCMS had received a request from the Attorney General's office asking for copies of bylaws, minutes of meetings, etc. for the past year. Legal counsel reviewed the letter and noted that cooperation becomes a question of policy. It was noted that the AG does have the power to make an investigative demand but the letter sent to the HMA is not of this nature.

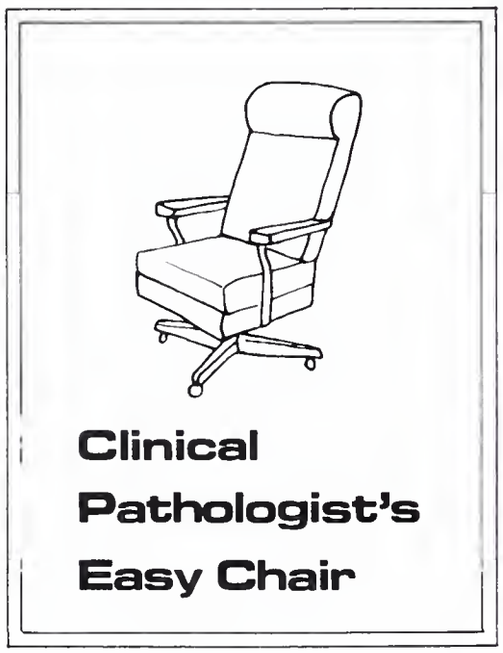
ACTION:

It was voted to not voluntarily forward the information requested. There were two dissenting votes.

ADJOURNMENT

The meeting adjourned at 10:00 p.m.

DOUGLAS B. BELL II, M.D.
Secretary



FRANCIS FUKUNAGA, M.D.

Drug Interference of Laboratory Test Results

Spurious laboratory results are often caused by medications and other factors such as food, changes in posture, physical activity and time of the day. Even smoking can alter lab values such as increases of the white blood cell count up to 30%. Laboratory results, therefore, must always be interpreted with caution to prevent erroneous conclusions.

Drug interference should be suspected whenever the laboratory result does not correlate with the clinical impression. A thorough history of drug ingestion, including nonprescription types, is essential since they can alter body functions or interfere with the methodology by some physical or chemical property. Some medications are notorious for interference with multiple laboratory tests. The oral contraceptives cause increased transferrin and serum iron, ceruloplasmin and serum copper, triglycerides and cholesterol, thyroxine binding globulin with resultant increased PBI or T-4 and decreased T-3 resin uptake, increased transaminases and alkaline phosphatase, glucose intolerance and liver damage with consequent increased serum bilirubin and BSP dye retention.

The substance being measured in the blood may also be found in some drugs. The most common example is the increased PBI caused by inorganic iodides such as in cough medications and amebacides and organic iodides in X-ray contrast media. Methyldopa, used in the management of hypertension, is a catecholamine and will therefore cause markedly elevated urine catechol values. The release of certain substances may increase under some conditions such as CPK from muscles caused by clofibrate and amphotericin B and intramuscular injections of ampicillin, carbenicillin and chlorpromazine.

Some drugs may affect metabolism. The barbiturates impair the ability of the liver to metabolize ammonia. Thiazides, ethacrynic acid and furosemide cause increased ammonia due to hypokalemia and alkalosis. MAO inhibitors decrease glucose by stimulation of insulin secretion. The phenothiazines can cause increased glucose by activating the adrenergic mechanism.

Protein levels may be altered by drugs such as the TBG increase with estrogens and oral contraceptives and decrease with anabolic steroids. Some drugs, such as Dilantin, compete for the TBG binding sites and cause a decrease of PBI and T-4.

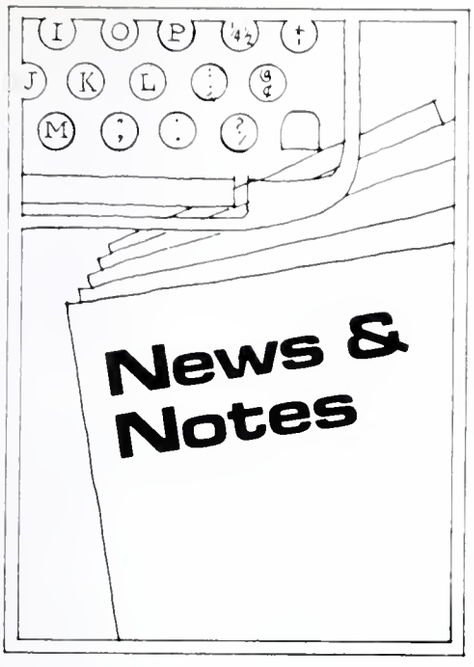
The absorption and excretion of various substances may be altered by drugs. Narcotics cause spasm of the spincter of Oddi with consequent increases of serum amylase, bilirubin and alkaline phosphatase. Barbiturates cause increased BSP retention. Diuretics cause decreased serum potassium due to increased urinary excretion and increased serum uric acid due to decreased renal excretion. Spironolactone, an aldosterone antagonist, causes increased serum potassium.

Some medications such as INH and Quinidine cause liver damage with consequent abnormalities of the liver function tests. Others such as 17-alpha-substituted steroids, phenothiazines, nitrofurantoin, indandione, anticoagulants and methyldopa cause cholestasis with resultant increased bilirubin and alkaline phoaphatase.

Finally, drugs can interfere with the methodology. Dextran interferes with bilirubin determination because of turbidity. BSP color is increased by the color of Pyridium and by the phenolphthalein in Ex-Lax and Feen-A-mint. Nalidixic acid causes false increase of urine glucose due to glucuronide conjugates; ascorbic acid may increase serum uric acid and the fluorescence of quinine, quinidine, tetracyclines and B-complex vitamins interfere with fluorometric procedures for catecholamines, metanephrines and cortisol. Hemolysis causes increased levels of some enzymes and potassium. About 50 mg per dl of dissolved hemoglobin (barely visible hemolysis) causes a 15 to 20% increase of serum LDH and about 2 to 5% increase of SGOT.

REFERENCES

1. Herman JE & Bassan HM: Liver injury due to quinidine, JAMA 234:310-311, 1975.
2. Fisch IR & Freedman SH: Smoking, oral contraceptives and obesity, JAMA 234:500-506, 1975.



HENRY N. YOKOYAMA, M.D.

God and The Medical Staff

CHIEF OF STAFF

Leaps tall buildings in a single bound
Is more powerful than a locomotive
Is faster than a speeding bullet
Walks on water
Gives policy to God

STAFF DOCTOR

Leaps short buildings in a single bound
Is more powerful than a switch engine
Is just as fast as a speeding bullet
Walks on water if the sea is calm
Talks to god

RESIDENT

Leaps short buildings with a running start and favorable winds
Is almost as powerful as a switch engine
Is faster than a speeding BB
Walks on water in a swimming pool
Talks with God if special request is approved

INTERN

Clears an outhouse
Loses race with a locomotive
Can fire a speeding bullet
Swims well
Is occasionally addressed by God

MEDICAL STUDENT

Runs into small buildings
Recognized locomotive two out of three times
Wets himself with water pistol
Dog paddles
Mumbles to animals

THE NURSE

Lifts buildings to walk under
Kicks locomotives off the tracks
Catches speeding bullets in her teeth
Freezes water with a single glance
SHE *IS* GOD.
(Submitted by **Henry Oyama,** former Kuakini Chief of Staff and now PSRO Quality Assurance Director)

Life In These Parts

The clean cut young man in the examining room greeted us with a worried smile and complained, "My girlfriend's doctor says I have Trichinosis." We conjured up all the serum tests and muscle biopsies the poor fellow must have had . . . But wait! . . . He doesn't look sick enough and besides, what was he doing here, if he did have Trichinosis . . . Aha! "You must mean Trichomonas rather than Trichinosis, don't you?" The anxious fellow brightened: "That's what I told my girlfriend, but she insists that her doctor said Trichinosis and that I keep reinfecting her . . . "

PSRO President **Winfred Lee** and Quality Assurance Director **Henry Oyama** were being interviewed by moderator **Ron Pion** on the HMA TV series "Health Conversations." Ron turned to Wini and asked, "What does P-S-R-O mean?" Wini replied forthwith: "Professional *Services* Review Organization." Now, Henry did look bemused, but kept a stiff upper lip . . .

Now that HEW has approved Hawaii's SHPDA (State Health Planning and Development Agency) as the official state health planning agency, SHPDA has the authority to allocate certain federal funds without federal supervision. Our SHPDA is one of 56 state health planning agencies created by the National Health Planning & Development Act of 1974 to improve the quality and accessibility of health care and control spiraling health costs. Hawaii is only the second state in the nation to gain this approval, Arkansas being the first . . .

A research team of the California Dept. of Health reported that 10 out of 211 babies designated as SIDS (crib deaths or Sudden Infant Death Syndrome) had Clostridium Botulinum isolated from cultures. **Dexter Seto,** professor of Pediatrics, UH Medical School was skeptical along with pediatrician **Calvin Sia.** Dexter feels that the California group has isolated one cause of infant death, but has not solved the mystery of SIDS. Dexter has been working with pathologists **Herbert Uemura** and **Yoshisugi Hokama** on the possibility that SIDS is caused by a respiratory virus . . .

"**Ed Dierdorff,** the Kailua doctor specializing in ear-eyes-nose-throat, concentrated on the latter Sunday as he sang the "Hawaiian Wedding Song" at the Delmary (the artist) and Berny Schanz ceremony." (Daacon Jul 19)

MMH Controversy: On July 31, DOH director George Yuen met with 35 to 40 doctors at Maui Memorial Hospital . . . **John Withers,** former MMH Chief of Staff reported that "the health chief had made a series of glib statements to a largely hostile audience . . . Yuen took s. . t for an hour and a half, like he was riding on waves . . . His latest ploy was to say he is appointing a 3-man committee . . . Another committee! An intelligent man could have listened a year ago!" Poor George! After the meeting, he was met by a delegation of RN's of the MMH Nurses Strategy Committee who were irritated at being barred from the earlier meeting and demanded instant reply to 10 specific demands. "Today's our deadline!" they insisted . . . George apparently "surprised at this unscheduled grilling took the heat for well over an hour without losing his composure."

The first total body CAT (costing $600,000) in the Islands has been in use at St. Francis Hospital since June. Queen's has had a brain scanner since Jan. '76.

Ten years ago, the Aina Koa residents had fought to a standstill a proposed nursing home atop the Kapakahi Ridge. In June, the residents fought a proposed "Human Performance Laboratory" with Honolulu cardiologist **Jack Scaff** as would be director at a public hearing before the State Board of Land and Natural Resources. The Board has now decided to return the Kapakahi Ridge acreage to a conservation designation . . .

Straub Clinic plans a "Wellness Clinic" early next year . . . Pediatrician **Tom Cashman,** Straub spokesman, explained that the clinic will be an extension of the Health Appraisal Center where multiphasic physical exams are now given . . . The concept is an extension of the traditional well baby clinics but involving adults instead . . .

Test-Tube Babies: In the wake of the test-tube baby success publicity of Cambridge University physiologist Robert Ed-

ward and British obstetrician Patrick Steptoe, **Ralph Hale,** chairman of the UH Med School Dept. of OB & Gyn, has already had two volunteers for a similar procedure. Ralph, however, was reluctant: "We're interested in doing implantation, but we want to wait and see what method they used first . . . There are a lot of things we don't have the answers to . . . Apparently Steptoe has figured something out, but it hasn't been published yet." Two years ago, Ryuzo Yanigamachi, UH professor of reproductive biology, had assisted Australian scientists in trying such implants, but had been unsuccessful . . .

Hawaii is one of 32 centers chosen to study the effects of propranolol on post MI patients for the next 4 years . . . This is the 2nd of two major nationally funded studies on post MI patients for Hawaii, the first being the Aspirin Study started in 1974. Principal investigator will be **Judson McNamara** and the study, granted $372,000, will be located at QMC. Researchers already feel that propranolol reduces the death rate in post MI patients by 25%, but no long term studies are available.

Cardiologist **Coolidge Wakai** had put the bug in the ears of two prominent local citizens, entertainer Danny Kaleikini and Thrifty Drugs president Sidney Kosasa who made the necessary contributions for the purchase of a $20,000 cardiac scanner for the Queen's cardiac lab . . .

Livingston Wong, chairman of the End-State Renal Diseases Network Coordinating Council of Hawaii and the Pacific announced that the council office has opened at the Gold Bond Bldg. . . .

HMA received a $15,000 grant from the Chamber of Commerce of Hawaii to produce a weekly ½-hour health education TV series entitled, "Your Body, Your Mind" which will be shown first on KHET starting in October and then "bicycled" through all the cable stations in the Islands . . . Moderators will be **Ron Pion** and **John Corboy** . . . Project directors are **Phil McNamee** and **Henry Yokoyama** . . . The tapes will be made available to the DOE . . .

Miscellany

Our humorist-wit **Philip Watt** reports that he saw in a medical journal picture quiz a color photograph of soft palate petichie. The differential diagnoses included strep throat and fellatio . . . (The patient agreed that it was probably the latter . . . A pearl for our changing times)

Philip also says the term "Gargoylism" is derived from "Gargoyle" and means "to over gargle" . . .

ENT man **Walter Young** nearly fell flat on his face when he tried to demonstrate how a moron ties his shoelace . . . Walter first placed his right foot on a high stool and then tried to tie his left shoelace . . .

Professional Moves

When it rains, it does pour! After a drought of 6 months, we have a real downpour which really began with a sprinkle at the end of June in Hilo . . . Pediatrician **Ruth Matsuura** announced the association of FuCHAT CHAN at Ka Waena Lapa'au, The Medical Center at 670 Ponahawai Street, and internist-oncologist **Leland Crandall** joined the Hilo Medical Group, Inc. at 1292 Waianuenue Ave. . . .

The cloudburst came in July . . . The Honolulu Medical Group enriched its ranks with pediatrician **Arthur Walter,** pulmonary man **Roy Adaniya,** and cardiologist **John J. Cogan** . . . The Kaiser-Permanente Medical Care Program gained GP **Willis Butler,** internist **Michael Chaffin,** ophthalmologist **Ivan Klimsa,** and pathologist **Anthony Cunha.** We met **"Lup" Pang** who proudly introduced his son, ENT man **Meredith Pang,** who joined the Pang Eye, Ear, Nose & Throat Clinic, Inc. at 1374 Nuuanu Ave. Another ENT man **Ronald Peroff** opened his second office at 98-1238 Kaahumanu St., Pearl City. Another pulmonary man **Bruce Soll** opened his office at Queen's Physicians' Office Bldg. Suite 804, internist **Alan Nelson** opened at Kailua Medical Arts Bldg., 407 Uluniu Street, and radiologist-nuclear med man **John Louis Soong** joined Radiology Associates, Inc. at Queen's Medical Center. FP **Jinichi Tokeshi** opened at **Homer Izumi's** former office at King Center Bldg., 1451 So King St.

On Hawaii, **Terence Young** relocated his office to **Wilmot Boone's** office in Kealakekua, Kona, and OB man **T.A. Barker** opened at the new Kealakekua Post Office Bldg. In Waimea, internist **John Dawson** joined the Waimea Medical Associates at the Lucy Henriques Medical Center . . .

On Maui, orthopod **Herbert Andrews** joined Michael McDonald at 95 Lono Ave., Kahului, and general surgeon **James Wienke** joined **John Withers** in the Maui Clinic, also in Kahului.

Elected, Appointed, & Honored

Eye man **Gerald Faulkner** was elected chairman of the board of trustees of the Pan-Pacific Surgical Association (PPSA) for two years succeeding **Donald Jones,** past chairman. **Cesar DeJesus** was elected treasurer, **Kazuo Teruya,** first vice chairman, **John Smith,** second vice chairman and **Frank Ceccarelli, William Hammon, Gail Li** and **Benjamin Tom,** trustees. The 2,500 member organization will have its next biennial conference at the Sheraton-Waikiki in Jan. 1980.

Benjamin Young, acting associate dean of John Burns School of Medicine, was accepted into the Ancient Order of Chammori, the highest public service award given a non-Guamanian by the Guam government. Ben supervises two special opportunities programs that the UH Med School has for the economically and educationally disadvantaged students. To date, two students from Guam have received their medical degrees and seven others are in various stages of training.

On Maui, Governor Ariyoshi welcomed the following physicians after they were sworn in by Second Circuit Court Judge George Fukuoka: **Helen Percy,** appointed to the Statewide Health Coordinating Council, **Paul Stevens** and Helen to the Maui County Subarea Health Planning Council, and HMA Prexy **Marion Hanlon** to the Board of Medical Examiners . . .

On Hawaii, the Big Island Division of the March of Dimes elected **Ruth Oda,** professional medical advisory chairperson.

On Kauai, **William Goodhue** was honored on Aug. 26 with a testimonial luau at the Hanapepe Recreation Center . . . The Wilcox Memorial Hospital elected pathologist **Rex Couch** to Chief of Staff succeeding **Robert Hamblin** and FP **William McLaughlin** Secretary-Treasurer succeeding **Thatcher Magoun. Arnulfo Diaz** was re-elected Vice President of the medical staff, **Robert Hamblin** remains as Chief of Surgery, **Patrick Aiu** as Chief of OB and **Peter Kim** as Chief-of-Medicine.

The following Oahu physicians were elected to membership in the Honolulu County Medical Society: **Kenneal Chun, John Cieply, David McEwan, Niranjaw Rajdev** and **James Sullivan . . .**

Nephrologist **Dudley Seto** reports that **Nami Kominami,** Straub internest has been elected to the prestigious Board of International Society of Dialysis . . .

Personalities

Straub pathologist and master linguist, **Jim Navin,** calls his good friend and orthopod, **Garth Morimoto,** "A Nut!" Jim's very logical explanation to wit: "Morimoto" in Japanese characters means "Base of Forest" . . . An acorn can be the base of a forest . . . Since an acorn is a nut, Garth is "A Nut."

Jim also attributes fellow pathologist **Tom Kobara's** prominent midriff to Tom's last name which in Kanji really means "Small Field" rather than "Small Stomach" though they sound alike phonetically . . . As Jim sez, "Well, since it's not 'small stomach', it has to be a 'fat stomach' "(Sounds logically illogical, but then, we must expect such logic from a

pathologist who loves to man the ER at Straub in his spare time.)

Hors de Combat

The State Dept. of Agriculture lifted its 5 month ban on hog viscera on July 21 . . . State Agriculture director John Farias, Jr. announced that DOH director George Yuen and he had agreed on pasteurization of pork parts at the slaughter houses and on stringent safeguards and sanitation requirements. Wayne McKinny, who has been waging a torrid campaign against Salmonella (Hawaii has 8 times the national average) commented, "It's a cheap way to go for the ethnic vote . . . " Wayne points out that during the recent ban, the Salmonella rate dropped from 60 reported cases in January to 24 in Feb. and that during a 1971 ban, the rate had dropped 50%. Wayne dolefully predicts a rise in Salmonella cases "because of human error . . . They'll get sloppy as soon as the pressure is off."

Entrepreneurs

"Dr. **Larry Reich,** the Honolulu doctor and author of 'From Fat to Skinny' flashes good news to mom Marian, the C & M fur buyer: He has a 2-page spread in July's Glamour Magazine." (Daacon June 21)

Richard Adler, Hilo physician and able medical columnist is chairman of the Ad Hoc Committee for the Improvement of Downtown Hilo which was formed to counter a proposal by Redeveco to develop a 39-acre $25-million regional shopping center outside the urban core of Hilo . . . The Ad Hoc Committee has the support of three major shopping centers and Richard speaks mysteriously of the "human scale" of the existing community in contrast to the "mechanical scale" when people have to drive instead of walk . . .

Kuakini Hospital will begin construction of a $9.5 million 10-story progressive health care center makai of the parking structure to accommodate long term, intermediate, and day care patients. With the addition, Kuakini will have 250 new beds plus space for 100 elderly day care patients . . .

Straub Clinic is also asking approval of a $10.5 million expansion to add an ambulatory surgery center, a 2-story coronary care unit, and an expanded emergency care unit so that the present 152-bed hospital can gain 6,000 square feet. The Clinic will add another 60,500 square feet with a 5-story office building and add 2 more stories to the parking structure for another 200 stalls . . .

Maui physician **Larry Aquilizan** had never painted until two years ago . . . But whenever he visited an art gallery, he would whisper to Alejandra, his wife, that he could do just as well . . . So Alejandra bought him brush, paint and canvas and dared him . . . In August this year, Larry had his own exhibit of fine paintings at the Wailea Art Center and Gallery. Larry feels that painting is easier than surgery because one doesn't worry about malpractice . . . Besides, if you make an error, you simply erase or cover up with more paint . . . (Submitted by the Maui County Medical Society)

Sportsmen

The St. Francis Hospital Tennis Tournament held on Sunday, July 30 saw 20 doubles teams competing against each other. The word is out that the team of **George Suzuki** and **Charley Ching** nearly upset the seeded team of **Dennis Maehara** and HMA singles and doubles champ **Ben Chang . . .**

Fred Dodge and son went for a "run into the sun"—a 37-mile hike across Haleakala crater which took them 9½ hours . . .

Visiting Professor

Ralph Cutler, Professor of Medicine and Chief of Division of Nephrology at U of Washington, was in town in August to lecture on "Hypertension, Drugs & Kidneys" . . . Herein are sobering notes gleaned therefrom:

Five random surveys involving a total population of 12,000 persons revealed that: 20% had BP's greater than 160/95; 50% were unaware of their hypertension; only 25% with hypertension were being treated; only 13% had their BP's under control . . .

The etiology of hypertension is multifaceted . . . Irwin Page speaks of a "Mosaic of Hypertension" which includes such factors as chemical, elasticity, cardiac output, viscosity, vascular caliber, volume, reactivity, etc., all interacting with tissue perfusion . . .

Classification of hypertension by kind: Essential vs Secondary hypertension which includes vascular, endocrine and renal hypertension . . .

A private Lansing, Michigan clinic survey of 350 hypertensive patients showed that: 91% are idiopathic; 1% due to oral contraceptives; 2% renal vascular; 2% chronic renal and 1% endocrine (1° Aldosteronism) . . .

Hypertension and life expectancy: Women aged 45 with BP's of 150/100 shortened their life expectancy by 8½ years; while men shortened their lives by 11½ years . . .

A 5-year VA study of men with diastolic pressures ranging 90-114 showed that the untreated group had 3 times greater cardiovascular morbidity than the treated group . . .

The Joint National Committee Report (JAMA 237:255 1977) recommends as follows:

1. All patients with diastolics greater than 105 should be treated.
2. In persons with diastolics between 90-104, treatment should be individualized with consideration for other risk factors (eg, diabetes, hyperlipidemia, obesity, etc.)
3. Evaluation can be limited to a few baseline tests.
4. "Stepped care" treatment is advocated as a cost effective approach.
5. Effective management includes plans for long term control.

Diagnostic Evaluation: Determine the severity of damage to heart, brain, eye and kidney.
Identify coexisting diseases.
Search for curable causes of hypertension.

Lab Workup includes: Hct, UA, chemistries (electrolytes, Na, K, HCO^3, creatinine), and EKG; Chest X-rays, glucose, cholesterol and uric acid are optional; IVP and renin profiling are of questionable value . . .

Renin-Angiotensin-Aldosterone (R-A-A) System: 27% have volume dependent low renin; 57% have normal renin; 16% have vasoconstrictive high renin . . .
Plasma renin measurements are unreliable; cannot predict etiologic mechanism; and are no help in management . . .
Low renin shows inability of the kidneys to secrete renin; thus it is a plasma sign of nephrosclerosis, rather than being related to the pathogenesis of hypertension . . .

Vital message! Treat the hypertension! Don't treat the renin level!

Therapeutic goals: Maintain diastolic pressures less than 90 with minimal side effects . . .

Therapy: 1. Diet: Na restriction (100 mg); caloric restriction.
2. Drug Therapy: Diuretics as a single therapeutic agent is most effective.

*Diuretics lower peripheral resistance and lower vascular reactivity with Na^+ loss . . . Thiazides are just as effective as Furosemide . . . Hence, reserve Furosemide for renal insufficiency and edema cases . . . For thiazide non-responders, try Metalazone or Furosemide . . .

*Do patients need K^+ replacement? On the mainland, most patients do not need K^+ supplement since K^+ moves intracellularly with the metabolic alkalosis . . . But here in Hawaii, the situation may be different because you perspire more . . .

Potassium supplements: a. Prophylactically for patients on digitalis and corticosteroids . . .
b. Therapeutically (or patients with serum K^+ less than 3.0 meq.)

Conference Notes

Straub internist **Vince Aoki** gave a most illuminating lecture on "Adverse Drug Reactions (ADR's) in the Elderly" at a Queen's Friday morning meeting . . .

Three factors cause a 2.5 times greater incidence of ADR's in the elderly:

1. Multiple drug use (3 times more drugs): Only 3% ADR's with less than 6 drugs/d; 25% ADR's with more than 6 drugs/d . . .
2. Multiple illnesses (4 times more): Factors include disease-drug interaction and symptomatic therapy with drugs . . .
3. Altered pharmaco-kinetics:
 a. Decreased absorption . . . Not a big factor . . . May even tend to decrease ADR's . . .
 b. Decreased distribution (important factor) . . . Less protein binding capacity due to less albumin and weaker binding forces in the elderly; therefore greater free drug and less volume of distribution . . .
 c. Metabolism (essentially unchanged in the elderly) but in cirrhosis there is less mass and in CHF, less blood flow . . . Drugs are metabolized in Phases I and II but are difficult to measure.
 d. Decreased excretion (most important factor): Excretory capacity at age 60 is 80% of normal and decreases 1%/year thereafter . . . (measured by creatinine clearance)
 e. Receptor Site (least understood): Elderly are more sensitive to drugs . . .

Summary: How to prevent ADR's: 1. Simplify the drug burden, ie., use fewer drugs whenever possible, and 2. apply known pharmaco-kinetics to the drug burden: eg., measure antibiotic blood levels, eg., gentamycin, tobramycin, etc.; and measure creatinine clearance: If renal function is compromised, then give smaller doses at shorter intervals or give the same dose at longer intervals (ie., fixed dose altered intervals). 3. Use 10% less dose per decade after an initial loading dose . . .

Miscellany

Ten Commandments for Living with People

1. Speak to people. Nothing is so nice as a cheerful greeting.
2. Smile at people. Takes 72 muscles to frown, 14 to smile.
3. Call people by name. Sweetest sound is one's own name.
4. Be friendly and helpful. If you want friends, be a friend.
5. Be cordial. Speak and act to prove everything you do is a genuine pleasure.
6. Be genuinely interested in people. Just try and you can like almost everyone.
7. Be generous with praise—and courteous with criticism.
8. Be considerate with others. There are often three sides to a controversy; yours, his, and the right side.
9. Be alert to give help . . . What we do for others lives and is immortal.
10. Add to all this a good sense of humor, loads of patience, a dash of humility and you will be rewarded many fold . . . John S. Swift Company, Inc. (Submitted by **Walter Loo,** our favorite golfer and real estate appraiser)

Hawaii, My Love,
or the Conquest of an Appendix

It was past midnight and when I came out
of the trance of concentration I realized that
we all had spent some harrassing moments
together, as only Hawaii uniquely allows.
In our all male team,
The surgeon was Japanese,
The assistant Caucasian from the European
continent,
The anesthetist Chinese,
The "tech" a Truk Islander born in Florida,
The "circulator" a Filipino, and
The patient a Hawaiian man who looked like a
Chinese.
None of us spoke flawless English.
The tangible result: a miserable appendix;
The intangible: a mostly unaware feeling
Of joy, gratitude, and love,
And an exuberant need to communicate.
Of course our rigid class mores did not
Allow such an expression.
Why can we hug and jump together
When winning at football? and,
What about a surgical tribal dance around
An appendix blue in the face and with
A hole in the neck?

HARRY KRAMER, M.D.

Our "Angels"

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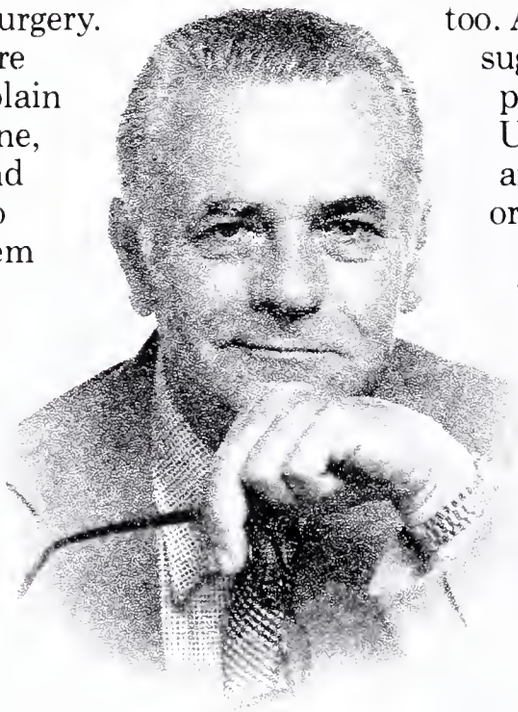
From what our HMSA members tell us, more doctors seem to be perfecting that old fashioned 'bedside manner.'

To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk about these important matters.

We think these are both healthy signs. We can all do our part to promote this kind of helpful dialogue.

We'd like to hear from you, too. Anytime you have a suggestion or question, please let us know. Usually we can have an answer for you in a minute or two.

HMSA — the efficient way, for you and your patients.



Old Fashioned Dialogue is Back.

HMSA Utilization Review Department
Ph: 944-2355

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VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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Reference: Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N.Y. 1969.

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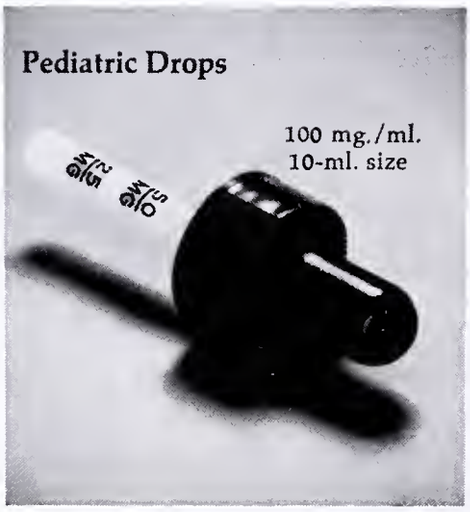
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Evaluation of Obstructive Jaundice by Ultrasonography

DAVID H. SAKUDA, M.D., *Honolulu*

• *With the development of gray scale ultrasonography, the detection of obstructive jaundice has become an easier task. Recent studies show an accuracy rate of 90% in the differentiation between obstructive and nonobstructive jaundice using gray scale ultrasonography.*[1,2]

The purpose of this paper is to illustrate the usefulness of diagnostic ultrasound in this role. As with any new technique, there are some potential pitfalls of which the referring physician may not be aware. These areas of difficulty will be described as well.

Materials and Methods

The patients presented here were examined utilizing a Picker EDC ultrasonoscope equipped with a 2.25 megahertz transducer focused at 10 cm. Scans were recorded on x-ray film. Except for "normal" examples, all cases described were proven at surgery or autopsy.

The sonographic evaluation of the jaundiced patient allows evaluation of the liver, gallbladder, common bile duct and pancreas in a single examination. The following cases illustrate some ultrasonic findings that are important in the evaluation of jaundice.

LIVER. The normal liver sonogram (Fig. 1) presents a homogeneous echo pattern, interspersed with vascular structures. Vascular structures, being fluid filled, appear as sharply demarcated echo-free areas within the liver. Normally, hepatic and portal veins can be visualized; however, the pattern of grossly dilated intrahepatic bile ducts is quite different and appears to be the most reliable sonographic sign of obstructive jaundice. The dilated intrahepatic radicals appear as tortuous branching "vessels" radiating from the porta hepatis. This pattern is seen in a large majority of patients presenting with icterus secondary to obstructing tumor (Fig. 2).

FIG. 1.—*NORMAL CROSS SECTIONAL HEPATIC SONOGRAM. The right and left lobes have a fairly homogeneous echo pattern. A prominent hepatic vein is seen centrally within the liver, anterior to the vena cava. Sp. = spine; IVC = inferior vena cava; Rt. = right.*

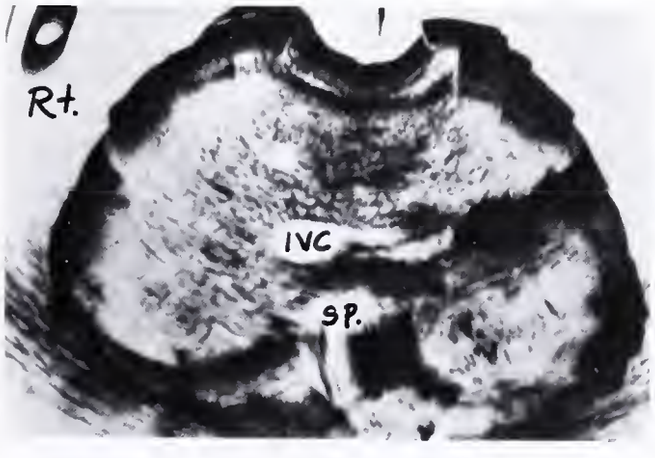
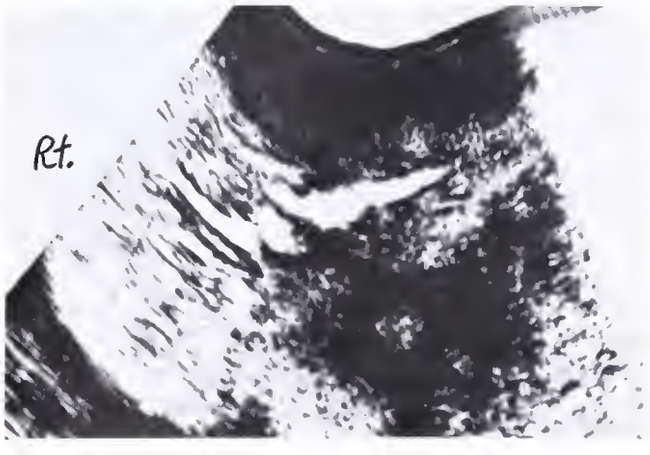


FIG. 2.—*GROSSLY DILATED INTRAHEPATIC BILE DUCTS. Cross sectional liver sonogram in a case of pancreatic cancer shows typical appearance of grossly dilated intrahepatic bile ducts.*



Detecting mildly dilated bile ducts by ultrasound is more difficult but can be accomplished reliably. Mildly dilated intrahepatic ducts appear as vascular structures accompanying the portal veins. Normally the intrahepatic bile ducts are not detected or appear considerably smaller than the portal veins.

Accepted for publication March, 1978.

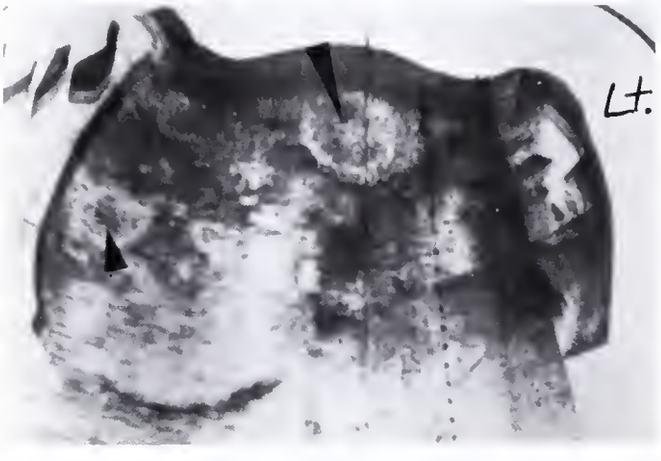
Department of Radiology, Kuakini Medical Center, 347 North Kuakini Street, Honolulu, Hawaii 96817.

FIG 3.—*HEPATOMA. Echogenic focus (large arrow) in the right lobe represents hepatoma, which obstructs the main left hepatic duct, causing dilated left intrahepatic bile ducts (small arrow).*



The hepatic sonogram can sometimes reveal the cause of jaundice. Figure 3 is an example of primary liver carcinoma, involving the right lobe and secondarily obstructing the left hepatic ducts. The tumor in this case is more echogenic than the surrounding liver parenchyma and is recognized as a focus of increased echoes. Some tumors are less echogenic than normal liver parenchyma and are detected as a relatively echo-free (sonolucent) focus. Figure 4 is a case of diffuse liver metastases discovered in a jaundiced patient. While most of the metastatic deposits appear echogenic, some have a sonolucent "halo," appearing as a "bull's-eye" configuration.

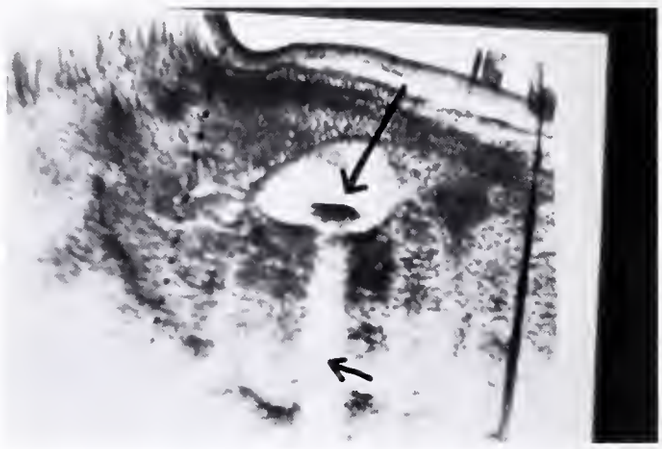
FIG. 4.—*LIVER METASTASES. Extensive liver metastases on a cross sectional scan. Some metastases have a "bull's-eye" configuration (arrows).*



GALLBLADDER. A dilated gallbladder is characteristic of tumors involving the lower bile duct. This sign is easily demonstrated by ultrasound. Surprisingly, these large gallbladders are often undetected on physical examination by the referring physician.

Cholelithiasis (Fig. 5) can be diagnosed by ultrasound with an accuracy rate of 90%.[3,4] Most of the errors in gray scale cholecystosonography are falsely negative sonograms. Falsely positive reports should be negligible in the hands of an experienced ultrasonographer. A gallbladder packed with calculi may not be diagnosed on the

FIG. 5.—*CHOLELITHIASIS. Longitudinal scan shows a large gallbladder with a 2 cm. calculus (large arrow) which produces intense echoes. The calculus in effect blocks sound transmission and casts an "acoustic shadow" (small arrow).*



sonogram, for the reason, probably, that the gallbladder itself is not recognized as a cystic structure since there is a lack of fluid within it. The calculi as well will not be detected due to the lack of a fluid interface. Thus, in a fasting patient without prior cholecystectomy, inability to detect the gallbladder, in spite of a technically satisfactory examination, is very suspicious for cholelithiasis.[5]

PANCREAS AND COMMON BILE DUCT. While the liver and gallbladder can be satisfac-

FIG. 6a.—*NORMAL HEAD OF PANCREAS. Cross sectional scan of pancreatic head (upper arrow) and normal common bile duct (lower arrow). The body and tail of the pancreas were visible at a higher cross sectional level.*

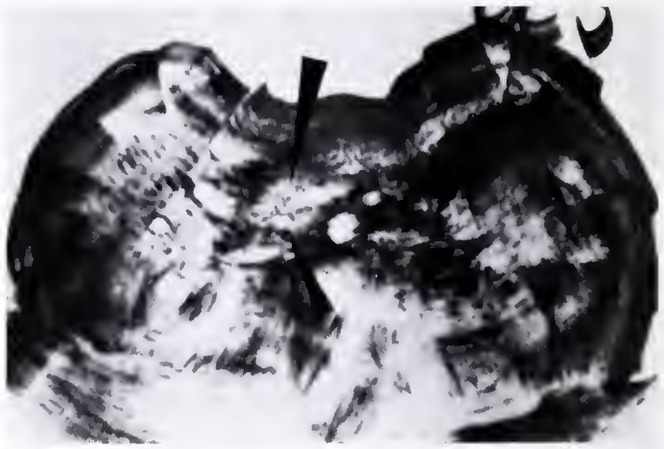
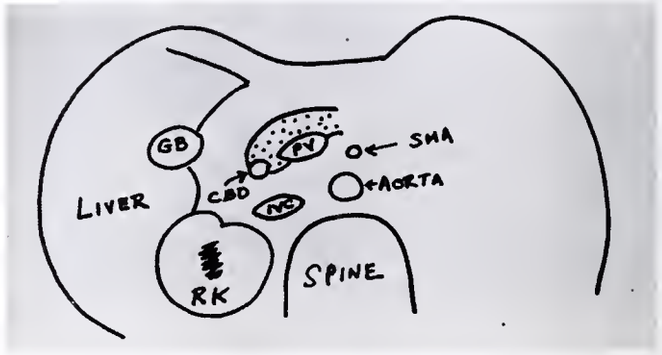


FIG. 6b.—*DIAGRAM OF FIGURE 6a. Dotted area represents head of pancreas. PV = portal vein; SMA = superior mesenteric artery; IVC = inferior vena cava; CBD = common bile duct; GB = gallbladder; RK = right kidney.*



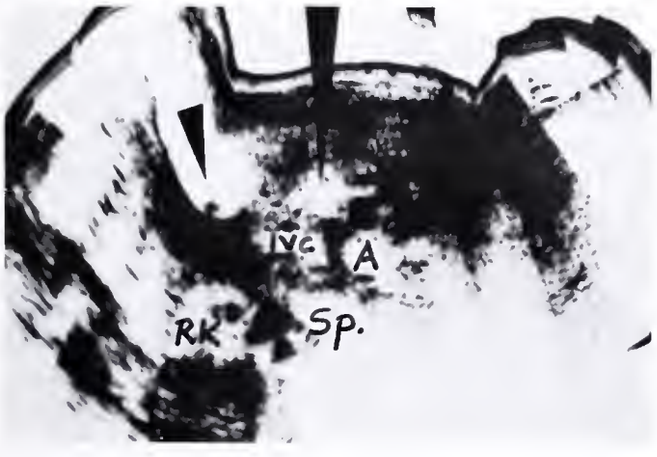
torily scanned in the great majority of patients, in our experience, the pancreas and lower bile duct

cannot be satisfactorily scanned in about 15% of cases. This is mainly due to interference from overlying gas-containing bowel, which effectively blocks sound transmission. Generally speaking obese patients and patients with ileus are difficult subjects to scan.

In contrast, detailed anatomy of the upper abdomen can be obtained in thin cooperative patients. Figure 6 is a normal cross-sectional scan at the level of the pancreatic head. The vascular landmarks around the pancreas, including the normal common bile duct, are well delineated.

Large pancreatic tumors are regularly detected by ultrasound. However, tumors smaller than 3 to 4 centimeters in the pancreatic area are generally difficult to diagnose. Figure 7 is an example of a pancreatic cancer, 4 cm in diameter, presenting with jaundice.

FIG. 7.—*CANCER HEAD OF PANCREAS. Cross sectional scan shows 4 cm. tumor (large arrow) and dilated gallbladder with small calculus (small arrow).*



The normal common bile duct is usually not identified on the sonogram. A grossly dilated common bile duct has a characteristic appearance as illustrated in Figure 8. A mildly dilated common bile duct must be differentiated from the portal vein which runs a similar course in the right upper quadrant. The common bile duct is identified as a tubular structure anterior and lateral to the main portal vein.

FIG. 8a.—*DILATED COMMON BILE DUCT. Longitudinal decubitus scan reveals tapered obstruction of dilated common bile duct (small arrow) from carcinoma of the pancreas. A dilated gallbladder (large arrow) lies laterally (anteriorly in this projection).*



FIG. 8b.—*PERCUTANEOUS TRANSHEPATIC CHOLANGIOGRAM. The dilated lower bile duct has a tapered obstruction as seen on the sonogram. The intrahepatic bile ducts are grossly dilated.*



In contrast to gallbladder calculi, common bile duct calculi are difficult to diagnose by the sonogram unless the bile duct is quite dilated (Fig. 9). Calculi impacted at the distal bile duct are usually not diagnosed because of a lack of fluid surrounding the calculi. Bile ducts packed

FIG. 9.—*COMMON BILE DUCT CALCULUS. Cross sectional scan shows dilated CBD with calculus (small arrow) and gallbladder calculus (large arrow). Prominent left lobe of liver (L) and normal pancreas (P) are visualized.*



with stones are difficult to detect for the same reason that gallbladder filled with calculi are frequently undetected.

Conclusion

Diagnostic ultrasound is a very useful noninvasive and relatively inexpensive technique for detecting obstructive jaundice. When the pattern of dilated intrahepatic bile ducts is present, ultrasound is diagnostic of obstructive jaundice. Frequently in these cases, examination of the pancreas, common bile duct and gallbladder will point to a specific cause of jaundice, and further diagnostic studies will not be necessary. In the equivocal or technically unsatisfactory sonograms, other studies such as the rose bengal isotope liver scan, transhepatic cholangiogram or endoscopic retrograde cholangiopancreatogram can be performed as indicated. About 10% falsely negative sonograms can be expected. This group may be reduced further in the future by improved equipment and technique.

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Nausea and Vomiting Associated with Fluphenazine: A Case Report

CLARENCE E. McDANAL, JR., M.D. *and* RICHARD A. MARKOFF, M.D., *Honolulu*

Nausea and vomiting have been reported as side effects of fluphenazine (Prolixin)[1]. When these adverse effects have occurred, they were quite severe. Dubourg reported one patient whose treatment had to be stopped because of persistent vomiting.[2] Verinder and Lavallee described two patients who developed intractable dystonias along with nausea and vomiting. They, too, were taken off parenteral fluphenazine treatment.[3] In their comparative study of chronic schizophrenic outpatients on fluphenazine enanthate and decanoate, Keskiner, Itil, and Holden stated that two patients developed nausea and vomiting, but they did not mention how these side effects were managed.[4]

Recently, we successfully treated with benztropine (Cogentin) a patient who suffered nausea and vomiting without extrapyramidal reactions while on fluphenazine decanoate.

Report Case

The patient, a 21-year-old single woman, had a one-year history of psychotic symptoms, fulfilling Feighner's criteria for schizophrenia.[5] As an outpatient, she had been tried on various oral psychotropic drugs with poor results.

The day prior to hospital admission she was given fluphenazine decanoate 25 mg by intramuscular injection. The next day she was admitted to an inpatient psychiatric ward following an overdose of benztropine mesylate, 34 mg. She had dilated pupils, dry mouth, paranoid delusions, grandiosity, loose thought associations, and visual and auditory hallucinations.

On the third hospital day her pupils returned to normal size and her mouth and lips appeared moist. That same day she became more agitated and threatened suicide. She was given fluphenazine decanoate 25 mg by intramuscular injection, was begun on oral fluphenazine 5 mg tid, and was placed on the locked security ward.

The next day the patient was calmer, but complained of nausea and vomiting. The oral fluphenazine was discontinued that day, and she was started on a clear liquid diet. She had as many as 5 vomiting episodes per day for the next 5 days with the vomitus described as "undigested food." These episodes were partly relieved by quiet bed rest and went away completely with sleep. She remained afebrile with stable vital signs and normal physical findings. She reported upper abdominal discomfort. She had no signs of an extrapyramidal reaction. A gastroenterology consultant evaluated the patient and suggested that we obtain more laboratory tests. The chest x-rays, upper gastrointestinal series, skull x-rays, electrocardiogram, pregnancy test, blood electrolytes, CBC, urinalysis, alkaline phosphatase, BUN, creatinine, glucose, cholesterol, LDH, SGOT, total bilirubin, uric acid, and total protein were within normal limits.

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In discussion of the case with other psychiatrists, they suggested a trial of benztropine mesylate by intramuscular injection. On her ninth hospital day and fifth day of nausea and vomiting, the patient was given benztropine mesylate (Cogentin), 2 mg IM. Within one hour her nausea and vomiting cleared completely.

She was placed on benztropine mesylate 2 mg bid and sent home the next day. Two weeks later the benztropine mesylate was reduced to 2 mg. At the same time, the patient did not wish to continue the parenteral fluphenazine, and was begun on fluphenazine 5 mg. She had one episode of nausea and vomiting. The benztropine mesylate was increased to 2 mg bid, the fluphenazine was increased to 10 mg bid because of auditory hallucinations, and there have been no further nausea or vomiting for 2 months. The patient's psychosis has also been well controlled on the oral fluphenazine.

Comment

Since the phenothiazines have been known for their anti-emetic property, it has been paradoxical that nausea and vomiting have been reported as side effects. The mechanism of these side effects has been unclear. As Shader and Harmatz stated, the incidence of these symptoms with placebo was similar to that with active psychotropic medications.[6] With regard to the long-acting fluphenazines, Ayd reported that autonomic side effects " . . . have been mild and not severe enough to discontinue treatment. They usually subside spontaneously as treatment with the same dose of drug is continued or after the dose is reduced."

How benztropine mesylate mediated its effects upon the nausea and vomiting in our patient was not clear. The anticholinergic properties of benztropine mesylate may have played the major role. Since we did not try one of the other anticholinergic drugs such as belladona or propantheline, we cannot be certain that this indeed was the case.

With our patient, it was also unclear whether oral fluphenazine played a role in inducing the gastrointestinal side effects. However, their persistence was most likely due to the long-acting fluphenazine, if indeed any drug was responsible, since the symptoms persisted for a number of days after oral fluphenazine was discontinued. The possibility exists that the nausea and vomiting were in fact not drug related and were produced by an intercurrent gastrointestinal illness. However, the absence of any findings to confirm such illness tended to make this improbable.

This case illustrated some of the difficulties that can occur with patients receiving long-acting parenteral phenothiazines. The diagnosis of phenothiazine-induced side effects should be considered in psychotic patients who present with nausea and vomiting without evidence of drug abuse, underlying infection or signs of extrapyramidal reactions.

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The Clinical Application of EMG Biofeedback Therapy for Muscle Contraction Headaches

WILLIAM T. TSUSHIMA, Ph.D., *and* ALAN B. HAWK, M.D., *Honolulu*

Tension headaches, or muscle contraction headaches as they are more properly designated, produce considerable morbidity throughout our society. Until recently, conventional treatment of tension headaches consisted of (1) a symptomatic approach using analgesics and/or tranquilizers, or both, or (2) psychotherapy aimed at understanding and removing the sources of conflict generating increased tension in the muscles around the cranium. In the past 5 years, a specific program of EMG-assisted relaxation training for tension headaches has been developed and proven effective in controlled outcome studies.[1-4] With EMG biofeedback technology, success rates of 75 to 80% are commonly reported.

Previous biofeedback outcome studies have been conducted in large university medical centers, typically with highly sophisticated instrumentation and substantial staff support. This paper evaluated the clinical application of biofeedback therapy in a private practice setting, with EMG biofeedback treatment of a group of patients with muscle contraction headaches.

Method

SUBJECTS. This study consisted of 13 patients diagnosed by their physicians as having chronic tension headache, with other causes for their headaches being ruled out. The 13 tension-headache patients consisted of 12 women and 1 man, whose ages ranged from 25 to 55, with a mean age of 34.6 years. Their mean duration of headache history was 9.4 years.

PROCEDURE. All patients kept a daily record of their headache activity on a Headache Record Sheet to provide quantitative data on headache levels during the period of treatment. The patients rated the occurrence and intensity of their headaches every 2 hours on a 6-point scale, "0" indicating no headache and "5" indicating very severe headache, and they began recording their headache activity one week before their first biofeedback session.

The biofeedback training consisted of 8 once-a-week 1-hour sessions, with frontal EMG activity being monitored through auditory signals. The frontal muscles were selected because of their apparent etiology in muscle contraction headaches.[1] During the training sessions the patients were also instructed in relaxation techniques with cassette tape recordings of instructions in progressive relaxation and autogenic training. All patients were told to practice relaxation at home for 15- to 20-minute periods twice a day.

Results

The patients plotted their headaches daily, and the data were averaged to obtain a weekly score. The data analysis consisted of evaluations of the mean hourly headache intensity levels and mean hours of headache per day over the 8-session treatment period.

The hourly headache intensity level over the 8-session period were subjected to trend analysis. For the tension headache patients, there was a significant linear trend, $F(1, 89) = 11.78$, $p<.01$.

Trend analysis was also performed on the hours of headaches per day over the 8-session treatment period. Again the linear trend for the tension headache patients reached statistical significance $F(1, 89) = 14.46$, $p<.01$. The trend analyses revealed marked reduction of headache intensity and duration for the tension headache patients (Fig. 1 and 2).

At the end of the 8 sessions, the patients rated their own improvement as either "marked," "moderate," "mild," or "no." The results showed that 6 reported marked improvement, 3 reported moderate improvement, 3 reported mild improvement and 1 reported no improvement.

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FIG. 1.—*Mean hours of headaches per day during eight biofeedback sessions.*

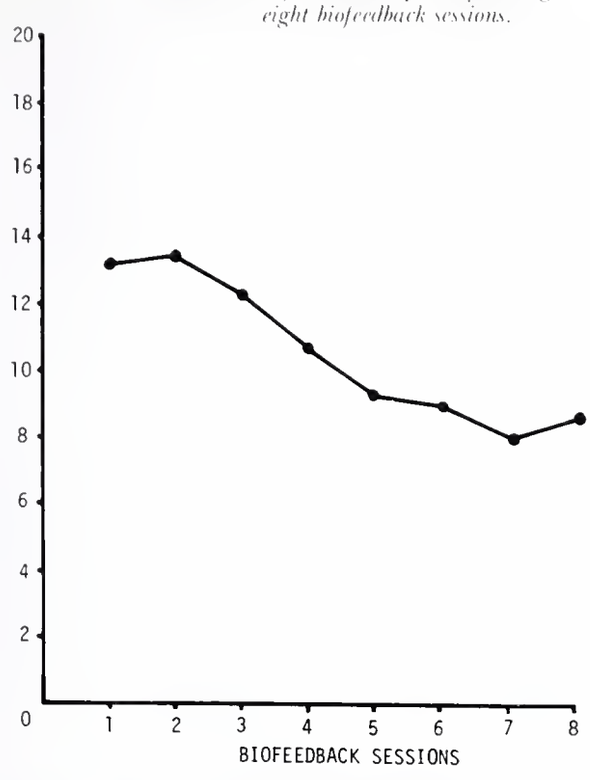
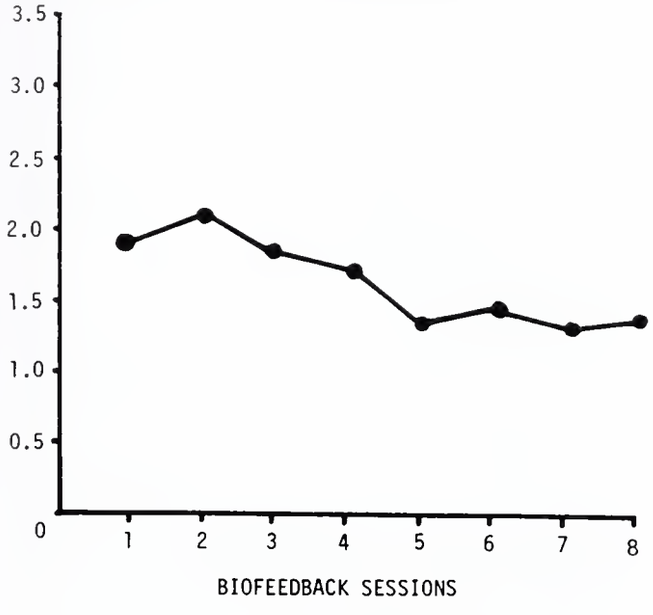


FIG. 2.—*Mean hourly headache intensity levels during eight biofeedback sessions.*



Thus, 9 of the 13 tension headache patients (or 69%) reported moderate or marked improvement of their headache activity.

Discussion

The successful reduction of headache intensity and duration for chronic tension-headache patients with EMG biofeedback therapy in this study were comparable to results reported by previous investigators. The data suggested that biofeedback treatment of headaches can be effective, not only in large medical centers where these methods were developed, but also in private treatment settings as well, with reasonable cost involvement. The results were particularly impressive in that the patients who were referred for biofeedback therapy in this study had failed to obtain benefit from the more convention medical techniques for the relief of chronic headache and were, therefore, significant therapeutic challenges.

The successful application of EMG-assisted relaxation training for tension headaches, according to Cox *et al*,[2] requires the following: (1) learning to reduce muscle tension levels with the aid of EMG feedback, (2) learning to increase relaxation throughout one's daily activities, (3) learning early recognition of the onset of increased levels of muscle tension, and (4) adequate early application of relaxation skills to reduce muscle tension before it has produced a headache.

In our experience, the skill of relaxing chronically tensed muscles is rather easily learned with an EMG biofeedback and relaxation training approach. Our clinical experience also verifies Cox's second point of the necessity of reinforcing the newly learned muscle relaxation with daily home practice, if headache relief is to be achieved. In the middle phase of this learning process, after reducing muscle tension becomes an established skill, patients frequently report awareness of low levels of muscle tension, of which they had not previously been aware. The institution of relaxation practice at this point will usually prevent the muscle tension from increasing to headache intensity. In our experience, Cox's third and fourth requirements will follow automatically with time if the first two are achieved and incorporated into the patient's daily routine.

It is important to emphasize that when headache is only one symptom in a more inclusive psychiatric disorder, eg, depression, there is little hope that EMG-assisted relaxation training will be effective. Treatment of the primary disorder is essential. For this reason, we stress the need for psychiatric consultation to ascertain the appropriateness of EMG biofeedback training for tension headaches.

In view of the many problems of medication with its side effects, toxicity, and habituation potentials, and the limitations of psychotherapy with its delayed results and considerable investment of time and money, the advantages of biofeedback therapy for the relief of tension headaches appeal to many patients.

The basic principles of biofeedback place emphasis on patient self-care and re-education rather than on an illness-treatment approach, and are in keeping with the present trends in holistic medicine and self regulation of health.

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Editorials

A waste of time.

The *Star-Bulletin* (8/29/78) reprinted, with permission, from *Patient Care* April 1978, excerpts from a telephone roundtable on Marijuana. The excellent article, if it has been widely read by the people of our community, and particularly by the young ones, the discussion of the pros and cons of the effect of pot-smoking may have a beneficial result.

We agree that were it not for the rigid laws we have against its use, there might be less inclination for naturally rebellious youth to challenge the "legality" of the acts of repression. Certainly the market value of *Canabis* in the field would go down, and organized criminality be reduced. "Afterall, if I choose to self-destruct, what business is it of yours? This mad world is overpopulated, anyway!" Of course, it is not that simple. It **is** society's business; society has to pick up the pieces of body, soul and properties, just as it does when a cyclist crashes without a helmet on.

We also favor the closing statement in the newspaper reprint, the one by psychiatrist David H. Powelson MD: ". . . when a legislature decriminalizes, and, in fact, legalizes marijuana, it also makes the very powerful educational statement that 'Marijuana is not a very bad drug'." The telephone panel did agree that the drug was dangerous.

But so is alcohol! There is proof that THC is the more dangerous because its half-life is five days, and it is fat, rather than water, soluble, which gives it a predelection for brain and gonad tissue, whereas alcohol is burned and excreted rapidly. However, setting aside arguments in this debate over alcohol versus pot, one can be harmed just as much by one as by the other, depending upon how much and how often.

Basic to the issue, however, and aside from the pharmacologic impact of drugs from alcohol to marijuana to heroin and beyond on man, is man's propensity to "daydream." He can do this without drugs, although drugs help him to slip into such a time-wasting trance that is not even recreational, nor creative. It is very true that alcohol, pot and the narcoleptics succeed in fending off, if only temporarily, thoughts of the USSR vs USA, Begin vs Sadat, Carter vs Congress, Ariyoshi vs Fasi, the guy next door threatening to shoot you, the guy in the other car cutting in ahead of you as you irrascibly wend your weary way home on H-1, 2 or 3, your kid demanding your attention, or your wife refusing to offer you the love and balm you crave and demand.

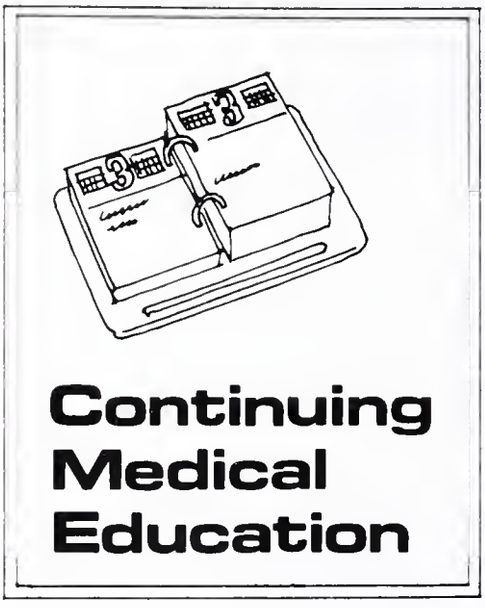
But, it is equally true that people think that they can "daydream" their cares away. It is equally destructive to the development of character, especially in the young. One of the big things we learn as we grow up is to concentrate on the task before us and to get things done; daydreaming denies that intellectual growth even more than does pot or alcohol. Time is wasted. Fantasy is not reality.

On the walls of the Harvard Medical School is a plaque:

> Life is short, the art long,
> occasion instant, experiment perilous
> and decision difficult.

For health's sake, keep busy! Daydreaming, alcohol, pot, whatever—even jogging—are cop-outs!

J.I.F.R.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/ Maui Mem. Hsp.

John A. Burns School of Medicine

1. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356

Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
2. U.H. Cardiology Grnd. Rnds., 1st & 3rd Tuesday, 5:30 p.m. Rm. 506 Univ. Tower, Queen's.
3. UH Grand Rnds-Ob/Gyn, Wed. 7:30-8:30 a.m. Kapiolani Hsp. Aud.
4. UH Perinatal Conf., Thurs. 3:30-4:30 p.m. Kapiolani Hsp. Rm. 815.
5. UH Seminar, 2:30-3:30 p.m. Kapiolani Hsp. Rm. 826. Fridays, 1st-Pathology; 2nd-Perinatology; 4th-Journal Club.
6. UH Conf., Friday, 3:30-4:40 p.m. Kapiolani Rm. 826.
7. Psychiatry Grand Rounds, 1½ hours credit, Friday 8:00 a.m.-9:30 a.m. University Tower, 6th Floor, 1356 Lusitana Street. Contact: Dr. McDermott at 548-3420.
8. Psychiatry Case Conference, 1½ hours credit, Tuesdays 10:00-11:30 a.m. University Tower, 4th Floor, 1356 Lusitana Street. Contact Dr. McDermott at 548-3420 or Dr. Wen-Shing Tseng.
9. University Medical School Grand Rounds, 3rd Thursday, 4:30-6:00 p.m.
 10/19/78—"High Density Lypoproteins and Athersclerosis." Coordinator: Dr. Christian Gulbrandsen. Mabel Smyth Auditorium.
 11/16/78—"Endomorphins, pain and drug dependence." Coordinator: Dr. Richard Markoff. Art Building, UH Manoa.
 12/21/78—"Hanson's Disease." Coordinator: Olaf Skinsness. Mabel Smyth Auditorium.

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.

(Contact CME Dept.-Kaiser for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Kapiolani Maternity Hospital

1. Tuesday Conference, 1:00-2:00 p.m. Kapiolani Hsp. Aud.
 1st—Didactic Presentation
 2nd—Perinatal-Neonatal Topics
 3rd—Obstetrics Topics
 4th—Gyn Topics
2. Neonatal Grand Rnds., Friday 8:00-9:00 a.m. Kapiolani Hsp. Nursery.
3. Tumor Board-Oncology Conf., 1st & 3rd Friday, 1:00-2:00 p.m. Kapiolani Hsp. Aud.

Kuakini Medical Center

1. Visiting Professor Program
2. G.I. Conference, 4th Tuesday, 8:00-9:00 a.m.
3. Nephrology Conference, 4th Wednesday, every month, 8:00-9:00 a.m.
4. Oncology Conference, every Thursday, 7:30-8:30 a.m.
5. Surgical Conference, 2nd and 3rd Friday, 1:00-2:00 p.m.
6. Surgical Mortality and Morbidity Conference, 4th Friday, 1:00-2:00 p.m.
7. Opthalmology Departmental Meeting, 1st Tuesday, every month, 1:00-2:00 p.m.
8. Medical Mortality & Morbidity Conference, 4th Tuesday, every month, 1:00-2:00 p.m.)

(Contact CME Dept.-Kuakini for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
6. SFH-UH Surg. Sat. Teaching Rnds. (except 4th) 7:30-8:30 a.m. UH 4 Classroom.
7. SFH-UH Hematology Conf., 4th Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
8. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
9. Tumor Conf., ea. Monday, 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Cardiac Surgery Meeting meets the 2nd Tuesday of the month, from 4:30-5:30 p.m. in the Doctor's Dining Room.
3. Friday Noon Conference meets weekly, from 12:30-1:30 p.m., in the Doctor's Dining Room.
4. Medical Grand Rounds meets the 1st Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.
5. Orthopedic Conference meets quarterly, from 7:30-9:00 p.m., in the Doctor's Dining Room.
6. Quarterly Professional Meeting meets the 4th Monday of the month, from 7:30-8:30 p.m., in the Doctor's Dining Room.

7. Surgical Mortality and Morbidity meets the 4th Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Local Hospitals, Honolulu
Type: I, 1 hr./day, 1 day/mo. from 12 mos.
Fee: None Methods: AV, O, Pan
Dates: All yr., 12 hrs. instruction

SPECIAL EVENTS

Oct. 1, 6, 1978	122nd HMA Annual Mtg. & AMA Regional CME Mtg. Hilkai Htl. Ala Moana Blvd., Honolulu. Contact: Mrs. Bess Chang at HMA for further info.
Oct. 2-6, 1978	Western Dialysis & Transplant Soc. Held at Hilton Hawaiian Village, Honolulu. 12 hrs. Cat. I. Contact: Arnold Siemsen, M.D., General Program Chairman, (808) 547-6522.
Oct. 8, 14, 1978	Am. College of OB/GYN. Held at Sheraton Waikiki/Kauai/Maui/Kona Surf. Cat. I. Contact: Wm. Hindle, M.D. 888 So. King St., Honolulu 96813, Ph. (808) 523-2311.
Oct. 8, 21, 1978	Tutor Ongologist, Byrl J. Kennedy, M.D., U of Minn. At all major hsp. on Oahu and neighbor islands. 1 hr. Cat. I. Contact: Am. Cancer Soc. Hi Div. (808) 536-2031 or check with your local hsp. for time.
Nov. 14-15, 1978	Temperament: A New Understanding of Individuals in Interaction. Col. of Hlth. Sci. & Soc. Welfare-U.H. Col. of Con. Ed. & Comm.
also on	Serv. Halekoa Htl, Waikiki-9:00 a.m.-4:00 p.m.
Nov. 20-21	UH-Hilo, Campus Center 9:00 a.m.-4:00 p.m. 12 hours Cat. I CME. Contact: (Manoa) 948-8581 or (Hilo) 961-9555 or 961-9354.
Nov. 16-17, 1978	Advanced Card. Life Supp. provider level Certf. Course, Royal Lahaina Htl, Kaanapali Beach Lahaina, Maui. 8:00 a.m.-5:00 p.m. 14 hrs. Cat. 1. Reg. limited to 24 phys. Contact: J. K. Sims, M.D. or Susan Norton, 1301 Punchbowl St. Honolulu 96813 (808) 547-4471.
Dec. 6-7-8-9, 1978	Am. Med. Joggers Assoc. 16 hours Cat. I. Contact: Kent Davenport, M.D. or Honolulu Marathon Assoc., P.O. Box 27244, Chinatown Station Honolulu, 96827.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



July 7, 1978, 5:30 p.m.
HMA Conference Room

PRESENT

Drs. Hanlon, Goto, Sia, Bell, Chinn, Mills, Walsh, Stodd, Lichter, Edwards, Howard, Winn, Fu, and Wigle. Dr. Catts was seated for Dr. Siemsen, Dr. Kuboyama for Dr. Roth. Also present were Drs. Char and Batten, plus Mrs. Berna Yim, Mr. V. Thomas Rice, Jon Won, Andy Saranchock, Tom Leineweber, Irene Wong, Bess Chang, Leslie Ajifu, Ceci Young, and Becky Kendro.

CALL TO ORDER

The meeting was called to order by President Hanlon.

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MINUTES

The minutes of the June 2, 1978 meeting were approved as circulated with the exception that the minutes reflect that the Council wishes to reply to the request of the Attorney General and to cooperate with that office; however, the Council believes that the collection of the data requested should be done under the appropriate mechanisms.

REPORT OF THE SECRETARY

Dr. Bell reported that the HMA membership as of May 30, 1978, was 871 members compared with a total of 886 at the same time in 1977. Dr. Walsh reported that one member had been dropped from the HCMS/HMA membership for non-payment to the building fund and recommended that the HMA return a pro-rated portion of dues to that member. The Council concurred with Dr. Walsh's recommendation.

REPORT OF THE TREASURER

Mr. Won reviewed the financial report for May 1978 and noted that the first increment of the EMS appropriation is due July 15.

ACTION:

The Council voted to approve the May 1978 statement subject to audit.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. EMS: Dr. Hanlon reviewed a request from the EMS program for replacement of three typewriters. He also noted that the Department of Health would like to meet with HMA regarding the EMS budget and possible cutbacks in the original appropriation.

ACTION:

It was voted to defer the equipment request until the questions regarding the budget appropriation are cleared.

Mr. Rice briefly reviewed the relationship of the EMS program to the HMA and noted the need to examine the organizational structure and administrative relationships. A summary proposal was drafted by Mr. Won and circulated to the Council for information.

ACTION:

It was moved and seconded that an ad hoc committee be formed of four out of the five past presidents, the president-elect, Mr. Won and Mr. Rice to look over the organization and report back to the Council at the next meeting. An amendment to the motion to add Dr. Livingston Wong to the committee was not passed as the Council noted that the committee could call forth any resource people they determined necessary.

B. Cancer Center: Dr. Hanlon reported that the National Cancer Institute has been notified of the HMA Council action regarding withdrawal from the Cancer Center of Hawaii. He noted also that the American Cancer Society, Hawaii Division, had taken similar action but then agreed to postpone action for six months to give the Center an opportunity to reorganize. Dean Jerrold Michael has been asked by the University of Hawaii to chair a committee to recommend solutions regarding the Center.

C. Cancer Commission: Dr. Batten reported that certain problem areas at the Hawaii Tumor Registry were alledgedly identified by a recent site visit although the Cancer Commission has not been given a copy of the report. It was recommended that HMA obtain a copy of the site visit report as well as any previous reports as quickly as possible to ascertain the extent of the problem. It was also noted that the Council should perhaps reconsider its previous action to relocate the Hawaii Tumor Registry.

ACTION:

It was moved and seconded that the Cancer Commission study the relocation of the Hawaii Tumor Registry in terms of HMA's present relationship with the CCH, in consideration of the relationship with the principal investigator, and in view of the various administrative problems.

D. CME: A letter from the Chairman of the CME Committee was circulated to the Council regarding the guidelines set by the AMA and the LCCME that any accrediting agency must have a person identified as a Director of CME. The Council directed President Hanlon to offer the position of Director of CME for HMA to Dr. Nadine C. Bruce at a salary level comparable to the budget determined for the Assistant to the President.

E. Public Health: The Communicable Disease Committee will convene in the coming month to consider the question of including rubella screening at the time of premarital exams as was proposed by the Department of Health before the 1978 Legislature.

F. Tel-Med: Dr. Lichter presented a progress report on the Tel-Med program. He noted that over 100,000 calls are expected to be received by Tel-Med in 1978. Tel-Med has been expanded to the neighbor islands and it appears that this is a very popular health education service for the community. Several exhibits were circulated for Council review and it was noted that perhaps CME programs or public forums could be planned around the tapes most frequently requested.

G. Annual Journalism Award: It was reported that the original journalism awards were apparently taken from the HMA offices and it was recommended that they be replaced by a wooden plaque similar to the President's plaque.

ACTION:

It was voted to purchase a plaque for the Journalism awards.

H. Internal Affairs: Dr. Bell reported that a meeting was held with medical service representatives regarding exhibits at the annual meeting. Concerns regarding traffic flow, exhibit fees, the question of whether to include exhibits, etc. were voiced and it was noted that the Convention Committee will continue to explore these areas of concern.

I. Voluntary Effort Committee: Dr. Mills briefly reviewed the Voluntary Effort program that is progressing rapidly across the nation. The VE program was established by the AMA, American Hospital Association (AHA), and the Federation of American Hospitals (FAH) to accept the challenge of Rep. Rostenkowski to establish a voluntary hospital and medical care cost containment program. A voluntary cost containment program has been established in Hawaii and the majority of the hospitals in Hawaii have pledged their cooperation in the program. The HMA and the AMA are partners in these programs.

J. HMA Auxiliary: Mrs. Yim reported that the

Auxiliary has hired a part-time secretary starting in mid-July.

K. PSRO: Mr. Won reported that the HEW has instituted a national second opinion program for Medicaid and Medicare patients. HEW is presently contacting organizations to develop referral centers for patients wishing to obtain names of possible consultants. The PacPSRO has agreed to participate in this program and believes that the county medical societies or state medical association should operate the referral service.

ACTION:
It was moved and seconded that the HMA postpone any decision to become involved in the development of second opinion programs until further information is received.

L. Report of the AMA Annual Meeting: Dr. Mills reported that there were 315 reports and resolutions presented to the AMA House of Delegates which now has 270 voting delegates. The Principles of Medical Ethics were modified to conform with recent FTC rulings and will be reviewed in detail by the Board. In addition, the following actions were taken by the House: (1) a reorganization of the student business section, (2) referred approximately fifty per cent of the recommendations from the National Commission on Cost Containment to the Board of Trustees for review, (3) discussed insurance priorities for psychiatric care, (4) discussed differential payment for physicians in teaching hospitals, (5) supported HR 222 which extends the National Labor Relations Act to hospital housestaff, (6) approved a report of physician manpower and medical education which is quite excellent, (7) agreed that the visa qualifying exam for foreign medical graduates would be the same as parts 1 and 2 of the National Examination, (8) Dealt with the causes of health care costs, and (9) voted to offer membership at 50% dues to those physicians who are in their first year of practice. Dr. Tom Nesbitt was elected president of the AMA and presented a rousing inaugural address.

REPORTS OF THE COUNTY MEDICAL SOCIETIES

A. Honolulu: Dr. Walsh reported that the HCMS Newsletter has been expanded a great deal. He noted that the HCMS PR Committee has put together a pamphlet for patients called "Hawaii Health Tips" which is being circulated to a test group of physicians. He noted that meetings have been held with reporters from both major Honolulu newspapers. He noted that HCMS has formed a Council of Medical Specialists and it is hoped that the specialty societies will play a greater role in the Board of Governors in the future.

B. Maui: Dr. Stodd reported that Maui physicians continue to experience problems with their state-run hospital. He noted also that the MCMS had met with representatives of the Hospital Corporation of America. This corporation has been asked by the Governor to do an in depth study of Maui Hospital with a view toward managing the hospital.

C. Hawaii: Dr. Wigle reported that the Hawaii County Medical Society asked him to request help from the HMA regarding their problem of declining membership. He noted that the majority of the physicians residing on the Kona side of the island are no longer members of the society and that it appears only those who favor unit rule are still members of the HiCMS. Dr. Hanlon noted that a committee had been appointed by the House of Delegates to look into the area of county/state problems and that the HMA will certainly look at the problems which have been identified.

ADJOURNMENT

The meeting adjourned at 10:00 p.m.

DOUGLAS B. BELL, II, M.D.
Secretary





Rodney Darrell Francis, M.D.

1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

OB-GYN



Decha Intaraprasong, M.D.

1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

RADIOLOGY



Chuen-Po Lau, M.D.

Punawai Clinic
Waipahu, Hawaii 96797

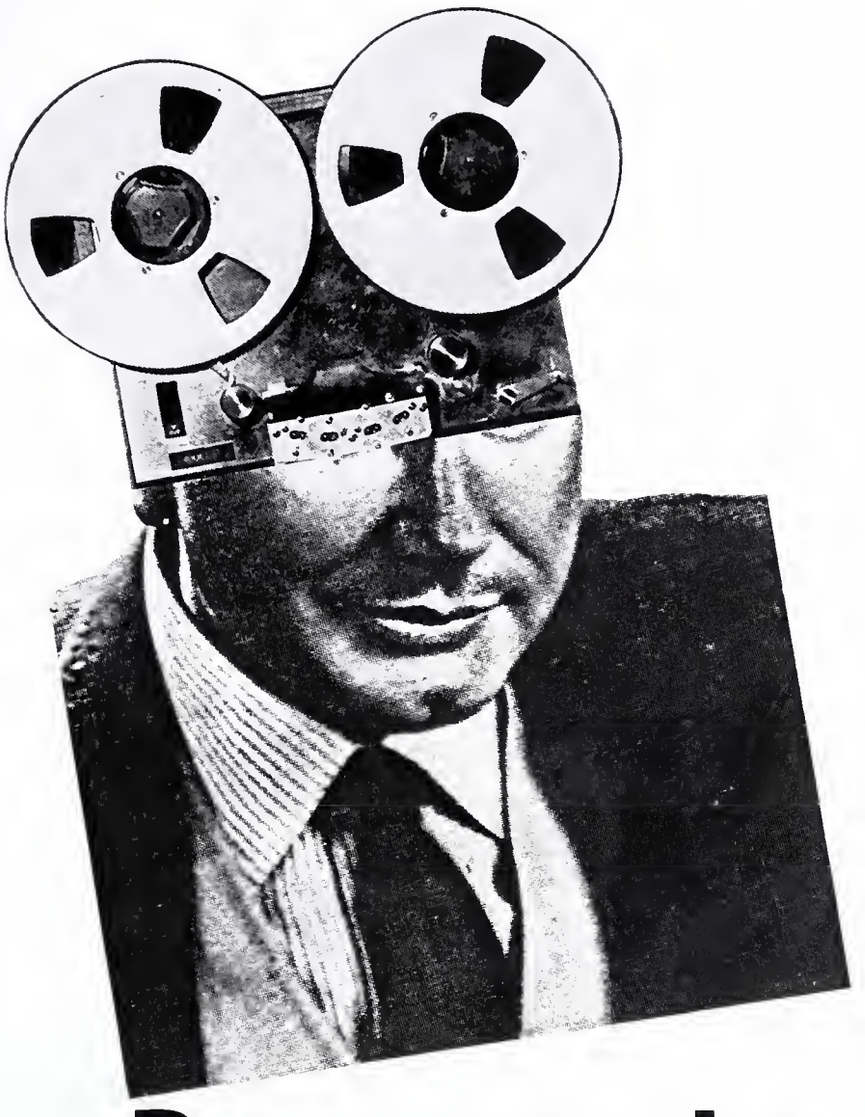
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John L. Soong, M.D.

1301 Punchbowl Street
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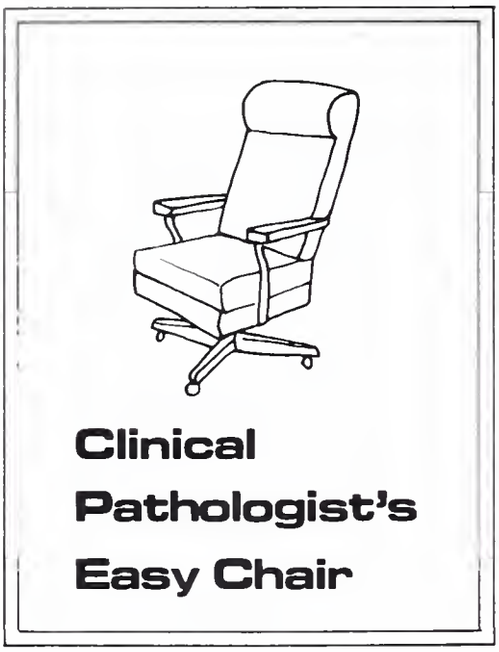
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Clinical Pathologist's Easy Chair

FRANCIS FUKUNAGA, M.D.

Clinical Toxicology

Poisoning due to drugs is an increasing problem. Many drugs are readily available; most found in home medicine cabinets. Ethanol is the chief drug of abuse in adults, salicylates in children. The symptoms of drug toxicity may mimic those of organic disease; the toxicologist is often asked to assist in the differential diagnosis. The initial examination cannot be exhaustive, but must include the most probable drugs. A more detailed analysis can be done later. Because patients frequently take more than one drug, the examination should include screening for drugs other than that suspected initially.

Coma is most often caused by the barbiturates but may be due to other nonbarbiturate sedatives, usually neutrals or neutral-behaving drugs such as methyprylon (Noludar), ethchlorvynol (Placydyl), glutethimide (Doriden), meprobamates and diphenylhydantoin (Dilantin). Drugs called psychoactives such as the benzodiazepines (Valium, Librium) and phenothiazines (chlorpromazine, promazine) also cause coma, as do propoxyphene (Darvon) and the narcotics.

The 5 classes of toxic drugs and chemicals are: (1) VOLATILES (eg, alcohol, carbon monoxide, cyanide); (2) ACIDS (eg, barbiturates, glutethimide, methyprylon, methaqulone, salicylates; (3) NEUTRALS (eg, meprobamates, ethchlorvynol, acetaminophen); (4) ALKALOIDS (eg, narcotics, propoxyphene, phenothiazines, benzodiazepines, amphetamines, CNS stimulants), and (5) METALS (eg, arsenic and lead). The drugs may be either free organic compounds or their salts. The salts are soluble in water, but the free compounds are soluble only in organic solvents. The pH at which the drug can be extracted determines the class. The acid compounds are solvent extractable at an acid pH, the bases or alkaloids at an alkaline pH, and the neutrals at any pH.

Blood is usually examined for the sedative drugs (volatiles, acids and neutrals), although the urine may be tested for some. The levels in blood are usually 2 to 3 times greater than in urine. The alkaloids, especially the narcotics and amphetamines, are found in larger quantities in the urine and often are not detectable in the blood, even with toxic symptoms and signs. Serum is usually examined for some alkaloids, such as the benzodiazepines, phenothiazines and propoxyphene.

Toxicologic screening may be by the qualitative thin layer chromatography or spot chemical tests, gas-liquid chromatography, high pressure liquid chromatography, spectrophotometry, radioimmunoassay, enzyme immunoassay, hemagglutination inhibition or fluorometry. Most procedures require a preliminary extraction process to "clean" the sample of interfering substances. Quantitative procedures require multiple extraction steps and therefore are more time consuming.

Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

New Members—Jinichi Tokeshi MD '75 UHSM is a transfer from Michigan and has been elected an Active member; he is taking over **Homer Izumi's** office and practice. **Gary McQueen** is a new Practicing Affiliate member. **Eileen Exton** is a new Active member practicing with Kaiser Permanente in Lahaina/Maui; she is a transfer from Pennsylvania. We have 5 new Resident Affiliate members: **Alan Chun, Lloyd Kobayashi** and **Lily Ning** at Kaiser; **Alan G. Moore** and **Harold L. Timboe** at Tripler. We welcome you all!

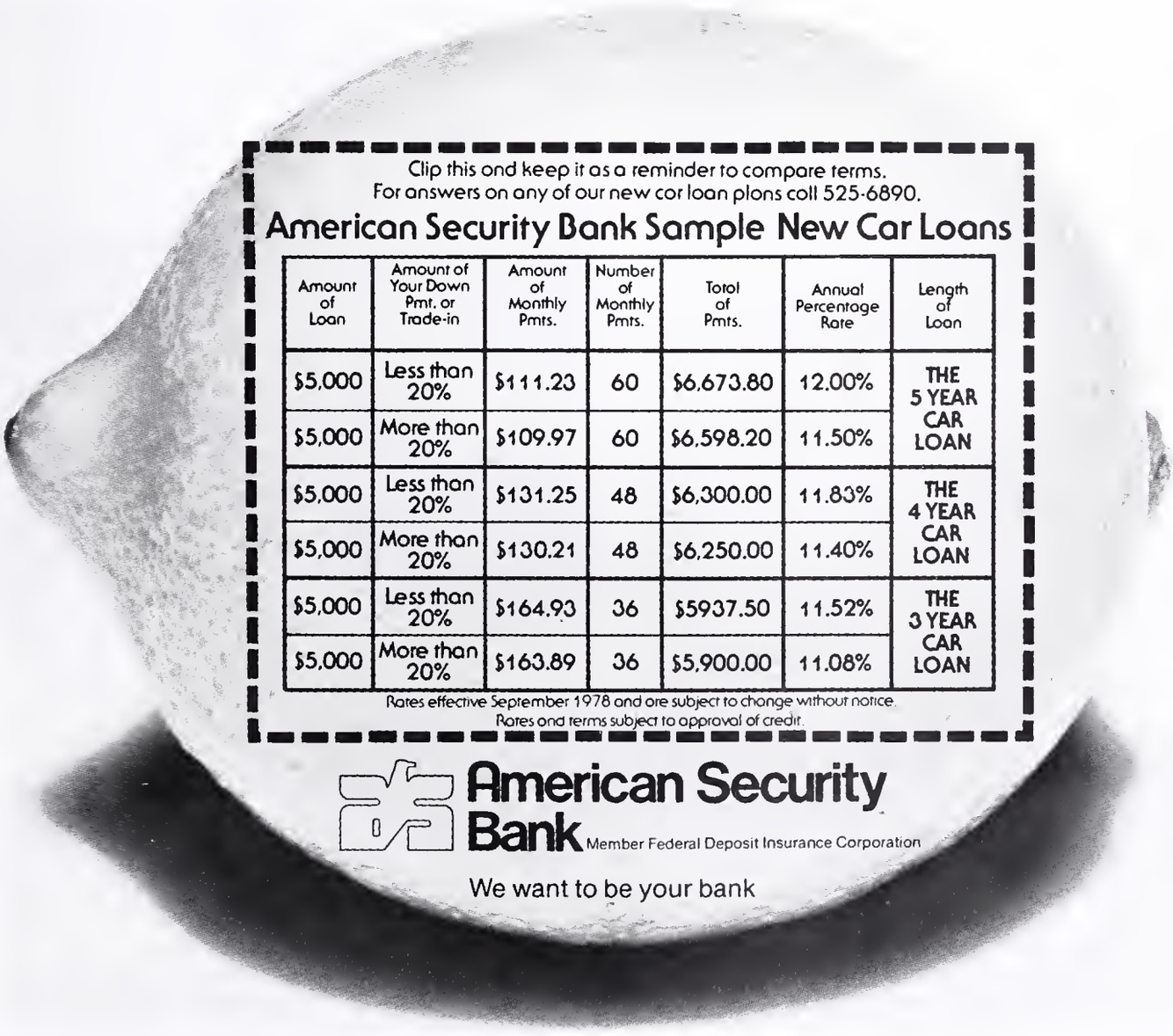
News of Members—Kevin Kunz UHSM '79 is away once more in Washington, D. C. **Roscoe Pebley** has moved to the state of Kansas but is still listed with us as an Inactive member. **Kats Izumi** on Maui is very welcome, sticking with us despite his retirement, and a Life member. **Bill Walsh** has also been elected to Life membership as of 1978. **Felix Lafferty** represented the HMA at the Molokai "Nine Percent Solution" conference on how to reduce health care costs. We feel the conference was snowed under by the paramedics and "consumers." **Glenn Stahl** has been elected to Active membership. **Felix** (again) **Lafferty** has been chosen Chairman of the A.A.F.P. Reference Committee on Reports of Officers and Committees to convene in San Francisco, 23 September. **Fred Dodge** has found himself unable to leave the Waianae Coast Comprehensive Health Center (the GSA breathing down your neck, Fred?) as Alternate Delegate to A.A.F.P.; his place is being taken by **Tom Cahill,** our President.

HAFP Council at its meeting 17 August at the Hon. Med. Grp. staff lounge, decided to comply with the "order" from Big Brother—the State Regulatory

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$5,000	Less than 20%	$131.25	48	$6,300.00	11.83%	THE 4 YEAR CAR LOAN
$5,000	More than 20%	$130.21	48	$6,250.00	11.40%	
$5,000	Less than 20%	$164.93	36	$5937.50	11.52%	THE 3 YEAR CAR LOAN
$5,000	More than 20%	$163.89	36	$5,900.00	11.08%	

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Agency—for copies of our Charter, ByLaws, Minutes, code of ethics, names and addresses of all the officers, etc. of the Chapter, but . . . we will bill the State for the work it entails. The U.S. Constitution guarantees each citizen "no work without pay." The American Revolution overthrew the British colonial system of "indentured servants" who worked without pay, as well as the "no taxation without Representation." Are you with us comrades, I mean colleagues?

Headquarters A.A.F.P. erred when they sent out CME printouts in August. You should get another one in December, because our medical licenses are issued 1 January. I'm not sure the Hq. Computer can take it: I filled mine up with every course, staff meeting & seminar I could think of or had a record of, choosing, wisely I hope, between "P," "E," and "N." I am way over my required 150 hours, most of them "P," however, so the Computer should relax. How about you? If you keep your own notes & notices current, it is a lot easier to tally at the end of each year, than to try to remember way back when! No one else can do this job but you, dear!

Next Dinner Meeting—for "P" credit, no less, is tentatively scheduled for 28 October, a Saturday, at the home of **Larry** and **Joan Wong** on the slopes of Diamond Head. Hq. A.A.F.P. has granted us blanket approval for "P" credit of 2 hours for—note correct & specific title—HAWAII CHAPTER BIMONTHLY DINNER MEETING to put on the yellow reporting card.

Kudos to **Harry Kramer** for the neat little bit about the ethnic appendix at the tail end of the August issue of the HAWAII MEDICAL JOURNAL!



Annual Review of Neurosciences

By W. Maxwell Cowan, Zach W. Hall, Eric R. Kandel, and with 28 contributing authors, Palo Alto, California, Annual Reviews, Inc. 506 pages.

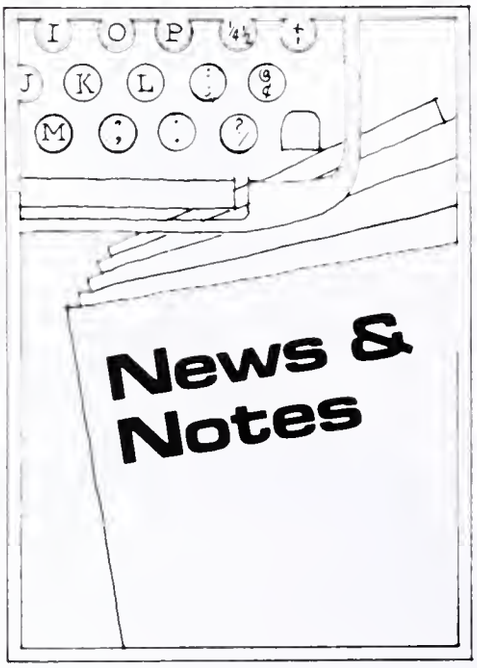
Neuroscience includes the traditional fields of neurophysiology, neuroanatomy, neurochemistry, and physiological psychology. The purpose of the first volume of the *Annual Review of Neuroscience* attempts to review current knowledge prevalent in the study of the nervous system.

Annual Review of Neuroscience includes fifteen well-written chapters by outstanding scientists with expertise in various fields of the neurosciences. The more exciting chapters discuss the circadian pacemakers in the nervous system, neural control of behavior, pain, neurophysiology of epilepsy, organization of neuronal membranes, control of locomotion, and sensory-evoked potentials in clinical disorders of the nervous system.

Owing to the current interest in the neurosciences, Annual Reviews, Inc., plans to publish additional volumes, with Volume 2 scheduled for publication in 1979. Purposed topics include the neurophysiology of vision, the biology of affective disorders, memory, neuronal modeling, and other exciting chapters.

I would recommend this book to clinicians as well as researchers. The current-review format will allow those interested to keep abreast of the rapidly changing field of neuroscience.

KENNETH K. NAKANO, M.D.



HENRY N. YOKOYAMA, M.D.

Professional Moves

The torrent continued unabated into August, esp with the groups . . . The Straub Clinic added dermatologist **Louis Morgan;** general and vascular surgeon **Eugene Ferris;** ER physician **Paul Lewis** and internist **Stephen Arnold** . . . The Kaiser-Permanente group added internist **Orin Gima;** OB Gyn men **Frank Nakamura, Alan Papst** and **David Kosnick;** ENT and cosmetic surgeon **Marcelo Obando;** orthopod **Edward Conn;** FP **Eileen Exton** (who will practice in Lahaina, Maui) and optician **Beryl Chun** . . . The Fronk Clinic added cardiologist **William Freud** and urologist **Kent Teruya** while its Pearlridge Clinic added ER physician **Arnold Hoffman** and internist **Steven Levine** . . . The Kona Medical Associates added general surgeon **Damkerng Pathomvanick** and pediatrician **Oravan Pathomvanich** . . . So much for the groups . . . In Honolulu, pediatrician **Alan Chang** joined **Roy Kaye** at 1319 Punahou St and pediatrician-FP **Gloria Natino Budna** relocated to 7 D Moanalua Shopping Center . . . On Kauai, pediatricians **Terry Carolan** and **Carlos Robles** teamed up as the Kauai Pediatrics Inc in Lihue, Kauai.

Life in These Parts

HEW Campaign to Contain Costs? Hawaii received a $1.6 million HEW grant and the State will ante another $100,000 to establish a Hawaii Fraud Unit to investigate and prosecute fraud by physicians and other health care providers receiving Medicare reimbursement. The Fraud

Unit is funded for 3 years and will have 10 full-time staff members including attorneys, investigators and accountants . . .

Cost Containment Committee: Our AMA delegate **George Mills** will chair the cost containment committee of the Hospital Association which will monitor hospital costs for the next 2 years. Vice chairman is **Thomas Battisto,** Straub administrator. The volunteer committee came into existence when President Carter sought legislation for a 9% limit per annum in hospital rate increases. The national rate has been running 16 to 17%, but had dropped to 13% this year . . .

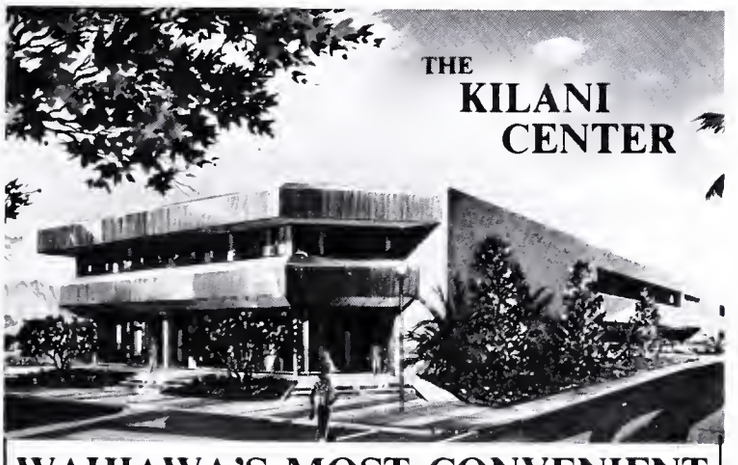
Boozed Up Doctors? Excerpt from Daacon's Aug 8 column: "Never seen so many boozed up doctors in my life, said a guest at Dr **Fred Fong's** wild party Saturday at the Diamond Head Circle home of his mom, Lucy Ma. About 350 doctors, nurses, stews, etc. showed up at the show place home which features a 100 ft. slide into the indoor, outdoor pool."

Budding Physician Artist: **Hilario Aquilizan** of Maui started painting 2 years ago on his wife's dare and recently had an exhibition at the Wailea Art Center. Hilario has donated his "Uniki" to the recently completed Hale Makua Nursing Home in Kahului . . .

Home Health Care on Lanai: A federally funded program administered by DOH has brought home health care to Lanai. Residents would prefer a free service, but it cannot be so because it is on a "reimbursable services" basis. Another problem for the visiting RN is the "horrendous roads" on Lanai . . .

Getting Involved: The **Ronald Fessenden's** of Pearl City hadn't intended to get involved, but for 2½ mos, they shared their small, 3 bedroom house with 12 Vietnam refugees. Ronald says, "We learned about giving and loving and growing."

Humor? "Add great Blue Ribbon waves. New gynecologist at Kaiser is Dr. **Alan R. Papst"** (Dave Donnelly's Hawaii).



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Health Care Act Endangered: Hawaii's Prepaid Health Care Act of 1974 is in danger of being voided by a federal override. Our Act requires every employer to provide health insurance for each worker and his dependents and is closer to Pres. Carter's national health insurance program than any other state program . . .

A Vote for **Dick Ando:** Our favorite marathoner-pediatrician and a 16 year veteran of the Board of Education, Dick Ando is running for one of the four seats in the 6th Senatorial District (Manoa-Waikiki) instead of seeking re-election on the Board . . . Dick needs all our kokua . . .

Aloha Aina: Hawaiian activist Emmet Aluli who now practices on Molokai says "Aloha Aina" (literally "Love of the Land") is "manifest on Oahu like the Waiahole-Waikane valley and the Campbell estate at West Beach called Lanikuhonna . . . These are places where the people have cared for the land, not for the money that can be extracted from it. Aloha Aina is a whole different perspective toward land use which is foreign to government and business."

Au Naturel? "Dermatologist **Norman Goldstein's** jumping out of his skin with joy at learning that his book, 'The Skin You Live In' is being featured in November's *Cosmopolitan* mag and gets a spot mention on 'Hollywood Squares' this afternoon" (Daacon Aug 28).

Cardiac Surgeon or Benihana Cook? "Currently recovering from heart surgery, the story around Straub is that before Sam Sanford went under the scalpel, he looked up at **Dr. Richard Mamiya** and quipped, 'Haven't I seen you working behind the teppan table at Benihana?' " (Daacon Aug 31).

The "U" Series: Austrian born **Henry Turkel** lectured on Maui about his phenomenal success with Down's Syndrome using a combination of drugs and nutrients he calls the "U" Series. Interested parents must go to see him at his Southfield Michigan clinic to receive a year's supply of medication because the nasty FDA will not allow any other physician or pharmaceutical company to produce the "U" series which costs $2,300 for a year's supply. He has over 400 patients currently on his therapy in the U.S. but his treatment has been in use for 15 years in Japan on 6,000 Down's Syndrome children in 60 Japanese universities and national hospitals . . . Alas, poor Henry has to limit his practice in the U.S. because of the FDA mandate . . .

Miscellany

The persevering father of eleven consecutive daughters was finally rewarded with a strapping son . . . Ten days later, a friend stopped to congratulate him, and asked, "Who does he look like?" The astonishing reply was, "Don't know . . . Haven't had a chance to look at his face yet."

(As told by **Felix Lafferty**)

The priest and the rabbi, childhood friends, were having a private confessional . . . The priest asked, "Rabbi, have you ever tasted ham?" The rabbi's face lighted with the memory, "Yes, once in the high school cafeteria." The priest teased, "Was good, wasn't it?" The rabbi nodded affirmation and then asked, "Father, have you ever had sex?" The Father remembered well, "Yes! Yes! There was that lovely girl I dated in college before I entered the seminary." The rabbi was quite explicit: "Beats ham anytime, doesn't it?"

(As told by **Irwin Schatz**)

Thought For The Day

"Blessed is the physician who takes a good history, looks keenly at his patient, and thinks a bit."

(By **Walter Alvarez**)

Hors de Combat

All hell broke loose on Maui when the wife of a retired newspaper man died of a stroke. The daughter who had been visiting tried several times unsuccessfully to call the MMH for an ambulance, but got no answer. The husband and a neighbor had to carry her to the car and he drove her to the hospital ER . . . Meanwhile the neighbor had gotten through to the ER and notified the staff that the patient was enroute. The gate to the ER was locked. A guard motioned the husband to drive to the front door where he was met by two young men who shouted at his wife to elicit a response. After 5 minutes, the men got a stretcher and carried her into the ER where an RN took her BP and started O_2 . . . 15 minutes later she started an IV . . . 30 minutes later the doctor appeared . . . The wife died next day . . . Deputy director of DOH, Henry Thompson was called to investigate and learned that a cardiac arrest was being treated in the ER, and that the two young men were ambulance attendants who had brought in the case . . . So there was a logical reason for all the delay . . . However, State Senator Anson Chong, Chairman of the Senate Health Committee which has been investigating conditions at MMH said there was no excuse for some of the conditions described . . .

Former MMH chief of staff John Withers, who has publicly endorsed Frank Fasi feels that Governor George Ariyoshi's commitments to improve conditions at MMH do not hold water. "We are now offered promises by the governor before an election . . . Must we continue to wait every four years for promises, most of which the State fails to keep?"

Pediatrician-child psychiatrist **Eberhard Mann** reports that the Sex Abuse Center which saw one male and 300 female rape victims last year will now be able to handle more male rape victims. Rape of males is apparently common in institutions such as the prison and the youth correctional facilities. Eberhard explains that "rape dynamics are the same for a male victim as for a female . . . Rape is an act of aggression aimed at humiliating the victims, rather than for gratification . . . "

Stephen Tenby, who apparently can't stand American underwear, returned from a vacation and underwear buying trip to Europe . . . Stephen and wife Celia lost their luggage on a flight to Genoa and never did find their bags till they returned to London. The bags had traveled to more cities than the Tenby's. "They even had Rome stickers on them," harrumphs Tenby, "a city I've never even visited." (Daacon).

Ralph Nader's health researchers report that consumers in 31 states have no right guaranteed by law to get copies of their medical records and urged HEW Secretary Califano to support legislation which would require all hospitals and institutions participating in Medicare and Medicaid to allow patients to inspect, copy and correct their records. The researchers feel that patients can avoid expenses and risks by relying less on physicians. One study estimated that 70% of all visits to doctors are unnecessary . . .

A recent survey by the Robert Wood Johnson Foundation of Princeton revealed that 37% of patients questioned complained about the cost of health care while another 28% complained about the time spent waiting to see a doctor . . .

With medicine on the defensive and with escalating costs, malpractice suits, and dehumanizing treatment by uncaring hospitals, there is a climate of dissatisfaction with and within the profession. Irving Page, *Modern Medicine* Editor Emeritus notes: "A combination of forces has conspired against physicians that has destroyed their ideals of human behavior and embittered them to the point of wanting out. Some are taking sheltered jobs in government, some are joining unions and some are cutting their working hours to the bone. Many want early retirement and to hell with practice."

Oops! Your Slip Is Showing

From a handout at a QMC OB Gyn Conference:

Don't use IUD: a. Previous PID or positive culture
b. Multiple *pardners* . . .
c. Younger than 25 years old.

Conference Notes

OB-GYN Conference at QMC (9-11-78)

Contraception: (Reports on Daniel Mishell Jr's lectures at recent USC Seminars by Lockwood Young and cohort).

I. Contraceptive Practice in US: A. Oral contraceptives (most popular) . . . Used by 34% of all married women; 65% of women married less than 5 years; 60% of women planning more pregnancies; 41% of all single women B. Sterilization (increasing in popularity): 43% of couples desiring no more children (22.6% men; 20.4% women) . . . Informed consent and counseling mandatory

II. Effectiveness of Various Methods: 1. Oral contraceptives and IUD: less than 1%/year 2. Barrier methods more effective in older women 3. Oral contraceptives effect due to ovulation inhibition

III. Side Effects of Oral Contraceptives: 1. Reproductive system a. Ovary: stromal fibrosis, No CA; b. Myometrium: fibroids c. Endometrium: BTB, amenorrhea, No Ca; d. Cervix: polypoid hyperplasia, No Ca; e. Breasts: decreased lactation, less benign breast disease, No Ca; f. Hypothalmus: 1/500 post pill amenorrhea; More galactorrhea and adenoma; delayed ovulation (EDC cannot be determined), no evidence of fetal abnormalities or increased abortions . . . 2. Other Organ systems: a. Liver: increased cholelithiasis (2 fold increase with 4 year use); b. CNS: nausea, headache, epilepsy, more migraines, strokes (3-9 fold increase with 5 year use) c. Skin: melasma, acne d. GU: infections e. GI: gastric flux; f. General: hay fever, chicken pox

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1. We evaluate the job order.
2. We search our files for related experience.
3. We develop new applicants - through news media.
4. We discuss the applicant with you prior to a final interview with you and the applicant.
5. We discuss the position with the applicant before setting up an interview in order not to use up your valuable time - with someone not interested or qualified.
6. Follow-up after each interview - we cannot assume that both parties are communicating and things are going well.

"Placements don't happen, they are made!"

Paul S. Isenburg, Ph.D.
Director
Medical Division

1441 Kapiolani Blvd./Suite 1203, Honolulu, Hawaii 96814/Phone 955-6686

IV. General Metabolic Effects: 1. Serum protein: decreased albumin and increased globulin (estrogen effect) a. Thromboembolism—increased 4-4 fold; 3/100,000 deaths/yr. b. Hypertension: 2.6 fold increase; 5% rise every 5 years (Reversible) 2. Lipids: increased triglycerides (estrogen) 3. Carbohydrates: lowered glucose tolerance, increased insulin level (Worsens existing DM; causes DM in women) 4. Electrolyes and water: fluid retention (5 lb) 5. Body weight: Positive nitrogen balance; 6. Vitamins and Minerals: Questionable clinical significance; 7. Tryptophan metabolism: depression, mood changes, diabetes . . . *Pregnancy in 1st trimester after stopping pill: 2 fold increase in galactorrhea, and ? more congenital anomalies

V. Atherogenic Risk: 1. MI 3 fold (Ages 40-44) 2. Associated Risk Factors: smoking, hypertension, hyperlipidemia, diabetes, obesity 3. Circulatory diseases: 4.7 times a. Heart disease and hypertension: 4.0 X, b. CVA 4.7 X (4.9x in current users and 4.3x in past users) *Risk is age related ie over 35 years old, duration ie more than 5 years, and a/c smoking . . .

VI. Current Recommendations for O.C. Use: a. Under 30 years: stop smoking b. 30-35 years old: Stop O.C. if more than 5 years, and stop smoking; c. Over 35 years old: Stop if smoker and used O.C. more than 5 years . . . A. Absolute Contraindications: a. Thrombophlebitis &/or thromboembolism b. CVA or CAD c. CA of breast or endometrium d. Pregnancy e. Hypertension f. DM or gestational DM g. Hyperlipidemic h. Gestational jaundice B. Relative contraindications: a. Oligo-menorrhea b. Depression c. Epilepsy d. Migraine HA's

VII. Follow Up Exams: q 3 mos BP & Wt; Annual: Pap, breast, abdomen, BP and Wt check; High risk group: glucose, triglycerides, liver functions

VIII. Pharmacology of O.C. A. Progesterones: Norethynodrel 1, Norethindrone 1, Norethindrone acetate 2, Ethinyl dioldiacetate 15, Norgestrel 30 B. Estrogens: Mestranol 1, Ethnylestradiol 1.7-2

IX. Recommendations: a. Reduce all to 50 ug or less
b. New starters: 30-35 ug EE

X. Formulations: 1. 50 ug estrogen—both mestranol and EE
2. Less than 50 ug estrogen—all EE (Less metabolic side effects and more frequent bleeding)

XI. Further Recommendations: 1. Stop 1 mos prior to surgery—may use progestin only for some protection 2. After AB, for less than 12 weeks gestation, start pill stat (Ovulates 2 weeks post AB); AB for 12-16 weeks; start pill 2 weeks later (ovulates 1 mos post AB) 3. Start low dose pill for teenagers when regular cyclic menses established (and sexually active) 4. Depot provera 150 mg q 3 mos for mentally retarded 5. Cardiovascular effects persist after being on pill over 5 years . . . Complications with pill after age 40 . . . Therefore shift to IUD . . . 6. Use another method for 3 months after stopping pill (Because of possible congenital defects or spontaneous AB) 7. Endometrial CA: 8 x increase with dose greater than 0.625 Premarin . . . Dose, method and duration related . . . There are 500 clinical osteoporosts cases for each case of endometrial CA . . . *Recommended Regimen for Osteoporosis Prevention:* 0.3 or 0.625 mg Premarin for 25 days and add Provera 10 mg/d from the 16th to 25th day . . .

Miscellany

The man and his wife were visiting the zoo near closing time, so they were alone . . . The male gorilla seemed quite attracted to the wife. He says, "He likes you . . . Try removing your blouse." The wife protested, but she too was strangely fascinated and does so . . . The gorilla goes wild . . . He says, "Honey! Take off all your clothes and let's see how he reacts." She does and the gorilla pants frantically. "Get up closer," he orders . . . She does, and he opens the cage door and pushes her in. "Now, tell him about your headaches," he chides . . .

(As told by **Louise Tokumaru**)

Farmer Jones' rooster died and his 50 chickens were lonely . . . Farmer Brown sends his rooster over after the virile rooster had finished with his own 100 chickens . . . The rooster finishes off the 50 chickens and then pounces on every farm animal around . . . the pig, the cow, the dog, the cat, then back to his chickens . . . Farmer Jones is astonished by the rooster's virility . . . Next morning, he sees vultures circling over his chicken coop and says knowingly, "Aha! I knew he over did it . . . " Farmer Jones sees the prostrate rooster and decides to bury him before the vultures got to him. As he approaches, the rooster opens one eye to wink and points eagerly at the circling vultures . . .

(Another **Louise Tokumaru** joke)

Lecture Series—Visiting Professor

E. Marshall Goldberg, from Michigan State College of Human Medicine, was the popular visiting professor of medicine in September. Not only was Marshall a superb lecturer, but his lectures were meaty and of practical value to the practicing physician . . . Herein are notes from his three remarkable lectures:

Medical Causes of Fatigue:

(Given at Kuakini Hospital)

"Medical causes of fatigue are pretty straight forward . . . 70% of patients seen complain of fatigue . . . When the last patient of the day says, 'Doc, I feel tired,' most of us get a sinking feeling . . . "

A. **Hyperventilation:** "The great masquerader was formerly syphilis, but today it is hyperventilation . . . Comprises 20% of patients complaining of fatigue and 90% of patients referred with the diagnosis of hypoglycemia . . . One of the commonest causes of fatigue . . . Symptoms include dizziness, syncope, paresthesias, chest pain, lightheadness, breathlessness (or awareness of breathing) etc . . . *Signs:* Chvostek's Test is 4 plus if positive at normal breathing; 3 plus if positive with 20 sec of hyperventilation (ie 1 deep breath/sec); 2 plus if positive at 40 seconds and 1 plus if positive at 60 seconds . . . Do Inderol Test to ddx functional vs organic ST-T changes . . . *Therapy:* a. Reassurance; b. Inderol Rx: causes respiratory alkalosis and increases lactic acid (I prefer Inderol to tranquilizers)"

B. **Hypothyroidism:** (Subtle cause of fatigue) Incidence: Mayo Clinic figures . . . 13% of thyroid disease patients: 25-30% hypothyroid, 5-7% hyperthyroid, and 65% euthyroid patients . . . Close relation of breast disease (including cancer) and hypothyroidism . . . Decreased T4 elevates TSH-RF which releases prolactin and TSH . . . TSH causes hypertrophy of acinar cells . . . 50% of breast CA a/c hypothyroidism . . . Some say thyroid Rx causes breast CA . . . Actually they have it assbackwards, ie hypothyroidism raises the prolactin level which in turn causes breast CA . . . *Symptoms* of hypothyroidism: 50 separate sy's . . . fatigue, lethargy, cold intolerance, hoarseness, weight gain, dry skin, paresthesias, deafness, etc . . . *Signs:* puffiness of upper lids, myxedema, "hung up" reflexes (eg Biceps and Achilles), big tongue, thyroid nodules . . . (Loss of Achilles tendon reflex is also a/c unsuspected diabetes mellitus) *Treatment:* Use TSH levels to titrate thyroid Rx (TSH 10 is euthyroid)

C. **Hypoglycemia:** Relatively rare disease . . . Tricky diagnosis to make . . . Can be cause of fatigue in normal people . . . Not a cause of impotence . . . *Symptoms:* Fatigue 1 hr before lunch or at 4 pm and a/c a family history of DM. *Dx:* Take GTT and Insulin levels together . . . Found in post gastrectomy patients (Gut insulin release factor) and in asthenic, high strung, chain smoking patients . . . I practically never use the GTT esp the 5 hr GTT (because it can be misleading) . . . Try to mimic the patient's symptoms ie take post glucola blood sugars at 2 hr, 3 hr and stat blood sugar with symptoms . . . Alcoholism causes hypoglycemia, not vice versa . . .

D. **Anemia:** 1. Esophageal dysphagia 2° Fe Deficiency 2. Folic Acid Deficiency: formerly dietary, but nowadays 2° to

birth control pills (> 5 years) . . . 40% have serum folic acid less than 3 . . . *Symptoms:* burning tongue, paresthesias, etc

E. **Liver Disease:** eg infectious mono; subclinical hepatitis etc

F. **Hypercalcemia:** Commonly found with SMA-12 . . . Incidence: 1/800 hospitalized patients . . . Etio: Excessive intake of Vit D and Vit A . . . Parathormone Test: 1/200 patients have elevated parathormone levels. *Symptoms:* Most pts asymptomatic . . . ie no renal stones, hypertension, etc; Proximal muscle weakness (May be a major manifestation of hyperthyroidism and of hypokalemia as well)

G. **Metabolic Edema:** (mostly in women) *Symptoms:* a. related to upright position ie progressive swelling with upright position; b. diuresis with supine position, thus nocturia; c. usually a/c diabetic GTT . . . *Diagnosis:* Weight am and hs . . . 3 lb wtg gain when up all day . . . Urine output drops with upright position . . . Etio: Aldosterone? *Therapy:* Ideally, a gravity suit . . . Symptomatic Rx with Aldosterone 4 tabs daily or Lasix q 2 or 3 d esp hs . . .

H. **Restless Legs:** Indescribable crawling, numbing sensation of legs . . . Etio: diuretics, varicose veins, diabetic neuropathy . . . *Treatment:* Quinine; antihistamines; Vit 3 400 IU tid in 90% pts and Valium hs in 10% pts . . .

I. **Occult Heart-Lung Failure:** Sy's: Fatigue, nocturia, gallup rhythm . . . Also in diffuse lung disease . . .

J. **Drugs:** (We fail to warn patients) esp with Aldomet . . . Also with Valium, Reserpine, Catapres, etc

H. **Depression:** Most common cause of fatigue and most missed diagnosis . . . 40% of senile dementia are depressed patients . . . Positive features: a. Ahedonism (lack of pleasure) b. Early morning awakening (Loss of REM sleep) . . . Clinically depressed when longer than 12 weeks (Depletion of norepinephrine and serotonin and rise in ACTH) Sy's: loss of wtg, loss of appetitite, loss of sex, loss of ability to concentrate . . . For clinical measurements: get into therapeutic levels with blood levels . . . Pt in depression will not commit suicide, but pt coming out of depression will . . . So get a psychiatrist . . .

Lab Workup for Fatigue: 1. CBC, 2. multiphasic 3. TSH 4. UA 5. Serum folate level

"The Promise of Antiplatelet Factors in Treatment of Stroke, Senility and Complications of Diabetes"

(Given at St Francis Hosp)

Factors: ASA, Anturane, Persantine, Dextran, Atromid, Indocin, Hydroxychloroquine, Inderol and Periactin . . .

Conditions: CVA, CAD, DM, Shunts, TIA, Senility

"Base life span should be 110 years . . . Cure CA and we add 10 years . . . Cure heart disease and strokes and we add 20 years . . . Known risk factors: a. Type A: adrenalin and free fatty acids; b. cigarettes: adrenalin and free fatty acids; c. hypertension: roughness of blood vessels; d. hyperlipidemia: increased platelet stickiness; e. hyperuricemia: 7-10 fold increase in CAD . . . "

"Venous circulation is slow flow, therefore red thrombus . . . prevented by heparin and coumadin . . . Arterial circulation is fast flow, therefore roughness of arterial wall results in platelet clot, then aggregation . . . Phase I and Phase II (Serotonin and ADP) Lab measurement of platelet function is difficult . . . "

A. **Factors:**

1. ASA in CVA prevention is fibrinolytic agent for platelet thrombi and prostaglandin antagonist . . .
2. Indocin: prostaglandin inhibitor
3. Periactin: antiserotonin
4. Inderol: antiserotonin

B. **Conditions:**

1. *Migraine* (may be 2° platelet thrombi) Use Inderol and Periactin to prevent platelet thrombi . . .
2. *Diabetes Mellitus:* I don't know what DM is . . . UGDP study shows that of all the currently available therapy, placebo has the least complications . . . My current philosophy for diabetes therapy is an antiplatelet regimen . . . If the blood sugar is less than 300 mg% and patient is asymptomatic, no RX . . . *ASA, Indocin, Anturane and Zyloprim are antiplatelet aggregation drugs and also anti-inflammatory . . . In DM, a. increased platelet aggregation and plasma activity ie platelets are stickier, esp in coronary and retinal vessels . . . b. sensitivity of platelets to araehidonic acid . . .
3. *CAD:* Type II hyperlipidemia clearly a/c CAD . . . Type IV has no relation . . .
4. *TIA:* A. Canadian Study involved 1,500 pts with TIA's . . . With placebo, 15% had strokes within 1 year and 40% had within 2 years . . . With ASA 4 tabs a day, 19% overall decrease in risk and 31% decrease in severe risk patients . . . 50% decrease risk in men (Ages 50-70) . . . Anturane had no significant effect . . . ASA with Anturane: Only slightly better B. US Study on Carotid A Disease: 180 pt's with macroocular blindness.
5. *Myocardial Infarction:* Anturane prevents sudden death in post MI pts. Placebo showed a 9.5% mortality the first year . . . Anturane showed a 4.9% mortality the first year . . . Prevents sudden platelet thrombosis; viz not effective in CVA's, but prevents sudden death in MI pts . . .
6. *Coronary A By Pass:* 900% increase in graft clotting if platelet stickiness present preop . . . Treatment with platelet factors eg Coumadin, ASA and Persantin prevents clotting . . . Propranolol 80 mg/d I. prevents MI and recurrent MI . . . Function not clear . . . Epinephrine blocking decreases platelet stickiness . . . 1/25 amount of ADP or epinephrine present with propranolol Rx . . . 2. Increases exercise tolerance 3. Decreases platelet stickiness
7. *Completed Strokes:* Persantine, ASA, Inderol and Thyroxine prevent recurrence, but which to use?

"My totally unscientific 3 drug combination" is the following . . . I have 150 DM's on this regimen . . . 1. ASA gr X bid (Ascriptin or with Maalox) 2. Inderol 80-90 mg/d in bid dosage 3. Zyloprim 300 mg od (Henry Ford Hosp experiment shows Zyloprim to be most effective in decreasing platelet

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In March 1975, the AMA took HEW to court over its Utilization Review Regulations which required review of all Medicare and Medicaid hospitalizations within 24 hours. The AMA contended the regulations constituted unlawful interference with the rights of physicians and patients. The AMA won its case and HEW withdrew the regulations.

The AMA also initiated legal action against HEW's Maximum Allowable Cost Rule, charging that the rule, which would govern the prescription of drugs for Medicare and Medicaid patients, intrudes on clinical decisions made by physicians. The case is now pending.

The AMA has also joined with co-plaintiffs, the state of North Carolina, the state of Nebraska and the North Carolina Medical Society, in a suit against the Health Planning Act of 1974 which gives the Secretary of HEW sweeping powers over nearly every aspect of health care.

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stickiness) or 4. Anturane 100 mg tid

8. *Senility:* Should senility be treated with antiplatelet factors? Chemical depression occurs in 40% of senile dementia . . . Pathogenesis: microaneurysms

9. *Systolic Pressure:* We used to say systolic elevation didn't count . . . but in Michigan we have a 300% increase in CVA incidence with systolic elevation . . .

Treatment of Thyroid Disease

(QMC, Kam Auditorium)

I. **Mysedema** Sy's a. hypothermia, b. hypotension, c. hypoventilation, d. hypotonia, e. hyponatremia, f. hypoglycemia, g. hypoadrenalism, h. CAD.

All elderly mysedema patients have CAD . . . 80% of all myxedema patients have CAD . . . DDX of myxedema and hypopituitarism: enlarged heart in myxedema, small heart in hypopit . . . Serum cholesterol rises because of decreased degredation in myxedema . . . "Fits, faints, convulsions, coma" of myxedema . . . High rate of ventilatory failure in myxedema . . . Death in myxedema secondary to arrhythmias (From thyroxine therapy) . . . Also angina and MI (with therapy) . . . 15-20% of elderly myxedema patients die in the 1st month of Rx . . . Transient rise in TSH before it falls with thyroxine Rx because pituitary is sensitive to thyroxine . . . Treatment program for myxedema: a. Monitor b. Heparin (to prevent pulmonary embolism & MI esp the first 2 days) c. Inderol (administer cautiously) 10 mg tid to 40 to 80 mg/d d. Cortisone (sometimes) 10-20 mg hydrocortisone tid e. Na-L Thyroxine: IV bolus (.3 mg to .5 mg Na-L Thyroxine) saturates binding sites and lasts 1-2 weeks f. D-Thyroxine (after 1-2 weeks) Potentiates catecholamines . . . Start with less than 1 mg/d, double every week till TSH is normal. "Two precepts: Do no harm . . . If treatment works, do not change."

II. **Hyperthyroidism**: Severe cases: Propyl thiouracil 6-8 weeks; surgery; RAI "Iodine induced myxedema is a sporadic generic disease" Treatment program: a. Inderol (3-5 days) 40 mg qid (Watch for asthmatic attacks) b. Then RAI(I^{131}) c. Continue Inderol for 2 weeks, then d. SSKI 2 gtts/d e. Thyroxine and SSKI for 6 months, then stop. Results of this program: a. 10-15% recurrence b. 20% hypo d. 60-70% remain euthroid . . .

III. **Iodine Induced Hyperthyroidism:** Rx with SSKI or other Iodine cpd for goiter can result in increased intracellular iodine, while I^{131} uptake remains less than 5% . . . Treatment program: a. Inderol or guanethidine b. TSH Rx for several days c. Get I^{131} uptake to 70-80% d. Then treat with RAI "I'm reluctant to give RAI to patients younger than 10 years old . . . "

A ____ Mother Writing To Her Son

Dear Son:

Just a few lines to let you know that I'm still alive. I'm writing this letter slowly because I know that you cannot read fast. You won't know the house when you come home—we moved. I won't be able to send you the address as the last family that lived here took the numbers with them for their next house so they wouldn't have to change their address.

About your father . . . he has a lovely new job. He has over 500 men under him. He is cutting grass at the cemetery.

There was a washing machine in the new house when we moved in, but it isn't working too good. Last week I put 14 shirts into it, pulled the chain, and I haven't seen a shirt since.

Your sister Mary had a baby this morning. I haven't found out whether it is a boy or a girl so I don't know whether you are an aunt or uncle.

Your Aunt Christine gave up the birth control pills when Uncle John bought a condominium.

Your Uncle Dick drowned last week in a vat of whiskey in Dublin Brewery. Some of his fellow workers dived in to save him, but he fought them off bravely. We cremated his body and it took three days to put out the fire.

Your father didn't have too much to drink at Christmas. I put a bottle of castor oil in his pint of beer. It kept him going until New Year's Day. I went to the doctor on Thursday and your father came with me. The doctor put a small tube in my mouth and told me not to open it for 10 minutes. Your father offered to buy it from him.

It only rained twice last week. First for 3 days and then for 4 days. Monday it was so windy that one of our chickens laid the same egg 4 times.

We had a letter yesterday from the undertaker. He said if the last installment wasn't paid on your grandmother within 7 days, up she comes.

Your loving mother,

P.S. I was going to send you $10, but I had already sealed the envelope.

Our "Angels"

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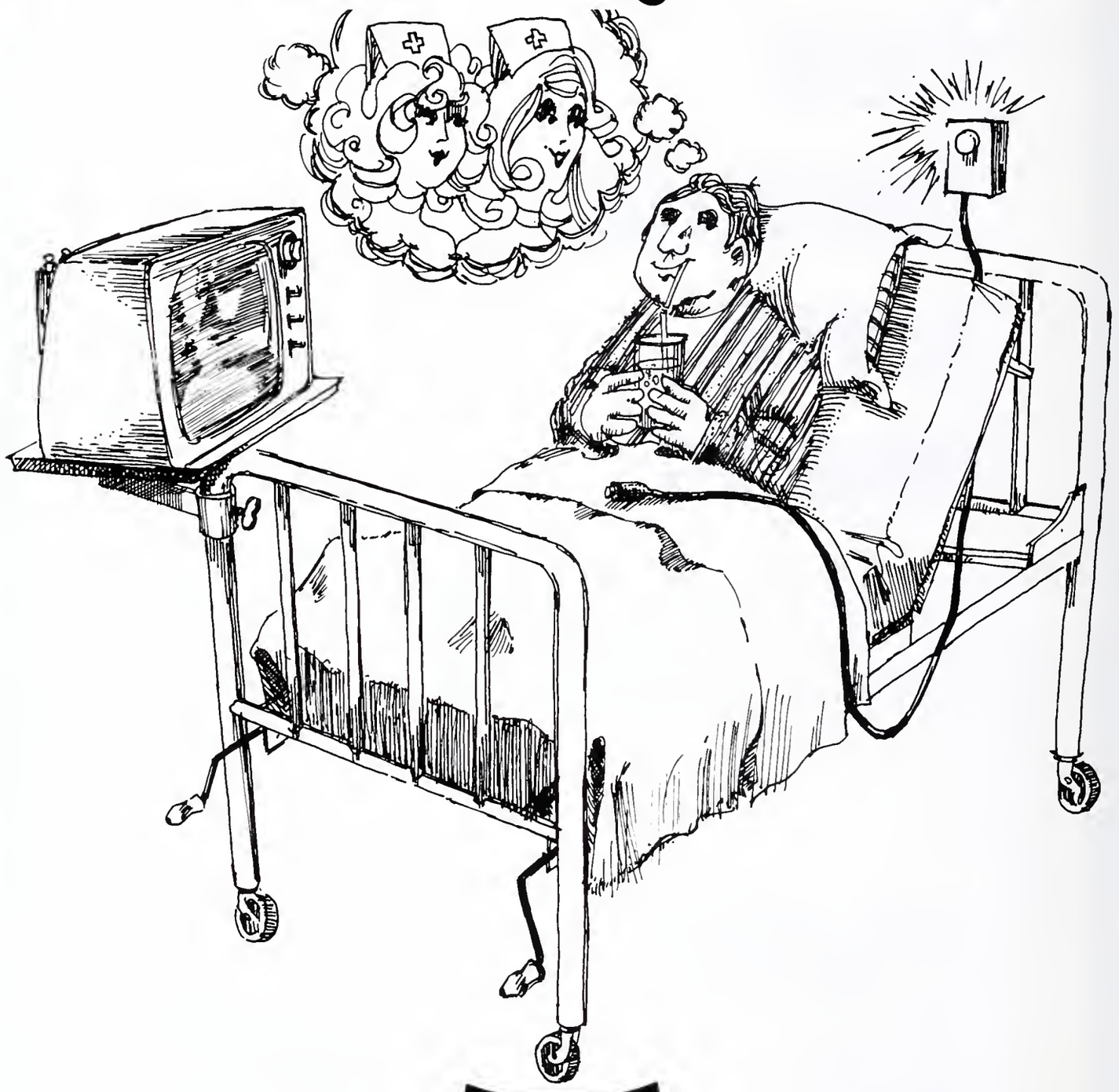
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OCTOBER, 1978
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Harry L. Arnold, Jr., M.D.
Editor
HAWAII MEDICAL JOURNAL
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Dear Harry:

If my memory serves me correctly, you were present at the Territorial Medical Society meeting in 1946 and 1947. One of those years the meeting was held at the Ala Wai Officers' Club and at that meeting, Dr. James R. Judd's 70th birthday was used as an excuse for a veritable bash. As the pink champagne gushed from bottles into glasses and from glasses slid smoothly down palates, Doctors Judd and Strode heaped praise on each other for their contributions and their excellent prowess in the field of surgery. One of the statements made by Dr. Judd has always remained with me and that was (and I can almost quote it directly), "The doctors of Hawaii are the greatest doctors in the world."

It is with humility that I accepted the award as Physician of the Year for 1978 at the banquet of the HMA on October 6, 1978. The words of Dr. Judd kept ringing in my ears and if the truth were to be known I walked up to the podium with a throat that choked a little.

Although there are many physicians in our community who have probably contributed much more than I have, I felt flattered and honored to be named as the recipient of the Community Service Award. I accepted it knowing full well that this could easily have gone to any one of numerous physicians in Hawaii. It was my good fortune to be selected as a representative of these physicians for 1978.

Through the HAWAII MEDICAL JOURNAL I thought it might be appropriate for me to thank all of those who were involved in selecting me for this award. Most of all I want to voice my expression of aloha to all the

Continued on page 318

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Stead, W.W. and Bates, J., in Harrison's Principles of Medicine,
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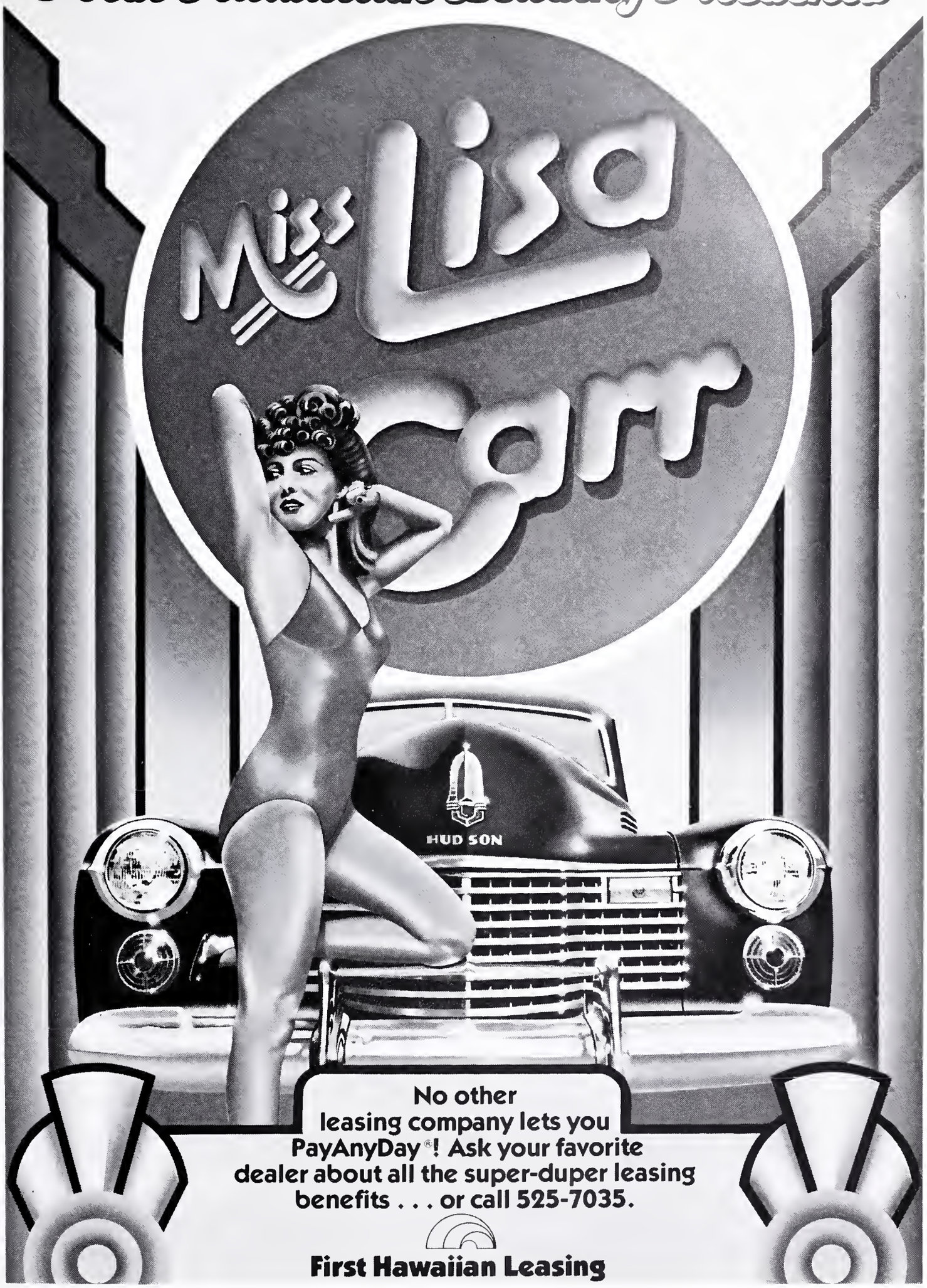
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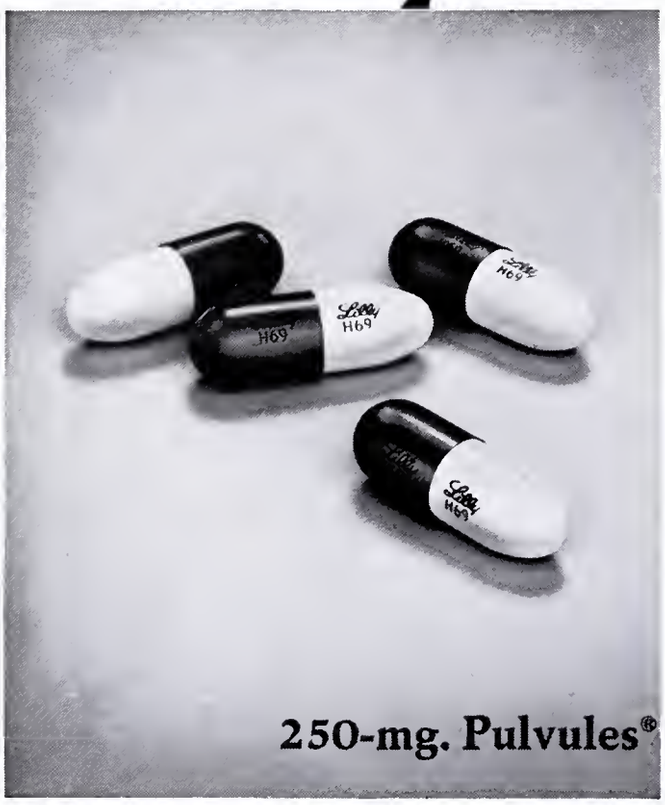
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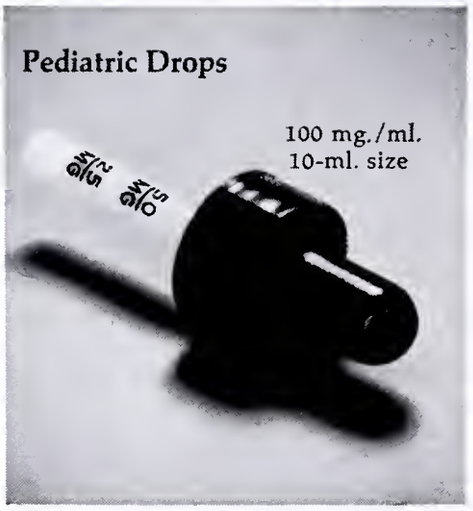
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Ninety-Seven Years of Mortality in Hawaii

ROBERT W. GARDNER* *and* ROBERT C. SCHMITT,** *Honolulu*

• *Recently constructed life tables for Honolulu in the late 19th century allow examination of mortality in Hawaii for almost a full century. Hawaii appears to be one of the healthiest places in the world to live, although there is no sign that the patterns of mortality and mortality change here have been significantly different from those observed elsewhere.*

Data on mortality are often cited not only as measures of the general health status of a population but also as indicators of the level of social and economic development. Unfortunately, above certain levels of mortality and below certain levels of development, data on mortality as well as on development tend to be poor, if indeed available at all. For Hawaii, life tables have been published for the period beginning in 1919-1920,[1] but none for earlier periods. Calculation of even the crude death rate for earlier periods is hampered by the absence of good data.

Recently compiled figures on mortality and population size in 19th century Honolulu, however, have enabled us to construct life tables for the city for 4 periods beginning with 1878-1879. Together with the later tables for the State as a whole, they give a fairly clear picture of mortality in Hawaii for almost a century.

Earliest mortality levels for Hawaii

The earliest information on Hawaiian mortality comes from an analysis of pre-contact skeletal remains found at Mokapu, Oahu. Charles E. Snow studied the remains of 1,171 individuals buried 200-300 years ago.[2] For all 838 adults and 325 sub-adults reported (8 fetal remains were excluded), the median age at death was 26.2 years, implying an expectation of life at birth (e_0 in life-table notation) of about 30 years. (The median age at death—x for $l_x = 50{,}000$—shows a changing relationship with e_0. Using model life tables,[3] a median age of 26.2 years would correspond to an expectation of life at birth of around 30 years, depending on the specific model chosen.) Only 4.4 percent of the skeletons were infants under 1 year, however, indicating that this figure of 30 years is probably too high. (For an expectation of life of about 25 years, for instance, one would normally expect at least 25-30 percent of the deaths in a stationary population to occur in infants.) Such an estimate must be viewed with great caution in any case, but it falls near the range of estimates for various pre-industrial populations. Weiss gives the following table of approximate values for e_0:[4]

GROUP	e_0 IN YEARS
Australopithecines	about 15
Neanderthals	about 18
Hunter-gatherers to the Neolithic	19-25
Proto-agricultural	20-27
Living primitives	22-29
Classic and medieval	22-29

The pre-contact Hawaiians, then, do not seem to have had exceptional levels of mortality.

19TH CENTURY DATA

Results of the 1847 census of northern/northeastern Kauai give indications of an expectation of life at birth of about 35-36 years (calculated from the Kauai age distribution and the total number of deaths,[5] using "West" model life tables[6]). The earliest island data on mortality by age, however, cover deaths occurring in Honolulu during the last 24 years of the 19th century. These statistics, compiled and published by the Board of Health in its annual and biennial reports, are thought to be reasonably accurate and complete. Mortality data by age were not

*Robert W. Gardner is Research Associate at the East-West Population Institute and Assistant Professor of Public Health, University of Hawaii.
**Robert C. Schmitt is State Statistician, Hawaii State Department of Planning and Economic Development.

compiled for rural Oahu and the neighbor islands until 1900; acceptable coverage on an all-island basis was not achieved until World War I.[7] Trustworthy life-table values for the Islands prior to 1920 are, accordingly, possible only for Honolulu proper.

The population base for these life tables is found in the censuses conducted by the Hawaiian government in 1878, 1884, 1890, and 1896.[8] The 1878 and 1884 census reports included data on the population of Honolulu by broad age groups. The 1890 and 1896 reports, by contrast, limited their age data to all-islands totals by ethnic group; for Honolulu, only data by ethnic group, without any age breakdown, appeared in the published reports. Estimates for Honolulu age groups for these years were based on the assumption that the age distribution for each ethnic group in Honolulu was identical to the all-island age distribution for that group. Such a procedure probably results in a more realistic estimate of age distribution for Honolulu than simply using the all-island distribution, unmodified.

Life tables were calculated for the 18-month period centered on the 1878 census, and for the 4-year periods centered on the 1884, 1890, and 1896 censuses. The broad periods were used to smooth some of the wide annual fluctuations observable in the data. A shorter period was necessary for 1878, because accurate reporting on a monthly basis with adequate age detail did not begin until April 1, 1878.

20TH CENTURY DATA

Mortality data for all of Hawaii became acceptably accurate around 1920. Death data are taken from vital statistics; the population base is obtained from the U.S. Census 1920 to 1970 and from estimates of the 1975 population.[9] The life tables beginning with 1920 are undoubtedly more reliable than the Honolulu tables, and show a smooth and steady fall in mortality. Several items should be noticed, however. The 1919-1920 life table probably reflects some higher-than-normal mortality resulting from the influenza pandemic that reached Hawaii in 1918 and continued until 1920. Deaths from influenza numbered 109 in 1918, 325 in 1919, and 866 in 1920, according to the Department of Health.[10]

The 1939-1940 life tables deliberately exclude the year 1941 in order to avoid the extraordinary mortality of the Pearl Harbor attack.

The 1969-1971 tables differ slightly from those published for almost the same period by the U.S. Department of Health, Education and Welfare.[11] Since the most recent total count of the population was the decennial census of 1970, the 1975 tables stand on a less firm basis than the 1970 tables and are consequently not emphasized in the tables and discussion.

Levels and trends of mortality

Due to space limitations, the life tables for the period from 1878 to 1975 are not presented here. (They are available from the Publications Office of the East-West Population Institute at xeroxing cost.) These tables contain a wealth of information about mortality during the century, and we can present only some highlights here. The earliest (1878-1879) and latest (1975) tables are probably the least trustworthy for their respective periods.

Comparisons of the 19th and 20th century tables are really comparisons of two different populations: Honolulu and Hawaii; all statements concerning changes from one group to the other should thus be viewed with caution. Furthermore, the past 97 years have been marked by massive shifts in the population composition of Honolulu and of the Hawaiian Islands as a whole. Between 1878 and 1896, for instance, the sex ratio in Honolulu rose from 132.1 to 168.5 males per 100 females. During the same period, the Hawaiian population declined from 65.7 to 26.5 percent of the all-race total. Similar changes occurred at the statewide level after 1920: between that year and 1975, for example, the Japanese and Chinese shares of the population plummeted, while numbers of Europeans and persons of mixed blood increased sharply. At least some of the variations in overall life expectancy may be attributed to these changes in population composition.[12]

Findings

1. Expectation of life at birth (Table 1, Fig. 1) has shown a continuous rise, although at varying rates. From 1878 to 1975, e_0 rose a total of 54 years; from 1885 to 1975, a total of almost 44 years. The period of fastest change, as measured by $\triangle$, the average annual gain in e_0, was between 1940 and 1950 (0.86 years per year); the rate of gain has fallen every decade since then (excluding the 1970-1975 half-decade). These rates of change in e_0 may be compared with data for other nations.[13] None of the maximum rates of increase for 11 western European countries was greater than 0.65 years per year (Netherlands, males, 1915-1926). However, the more recently the "mortality transition" has come to a country, the more rapid its rise in e_0; values of well over 1.00 years per year are not uncommon for the post-World War II period.[14] Hawaii's experience is thus fairly rapid for a population at its level of development and date, but unexceptional compared to many places.

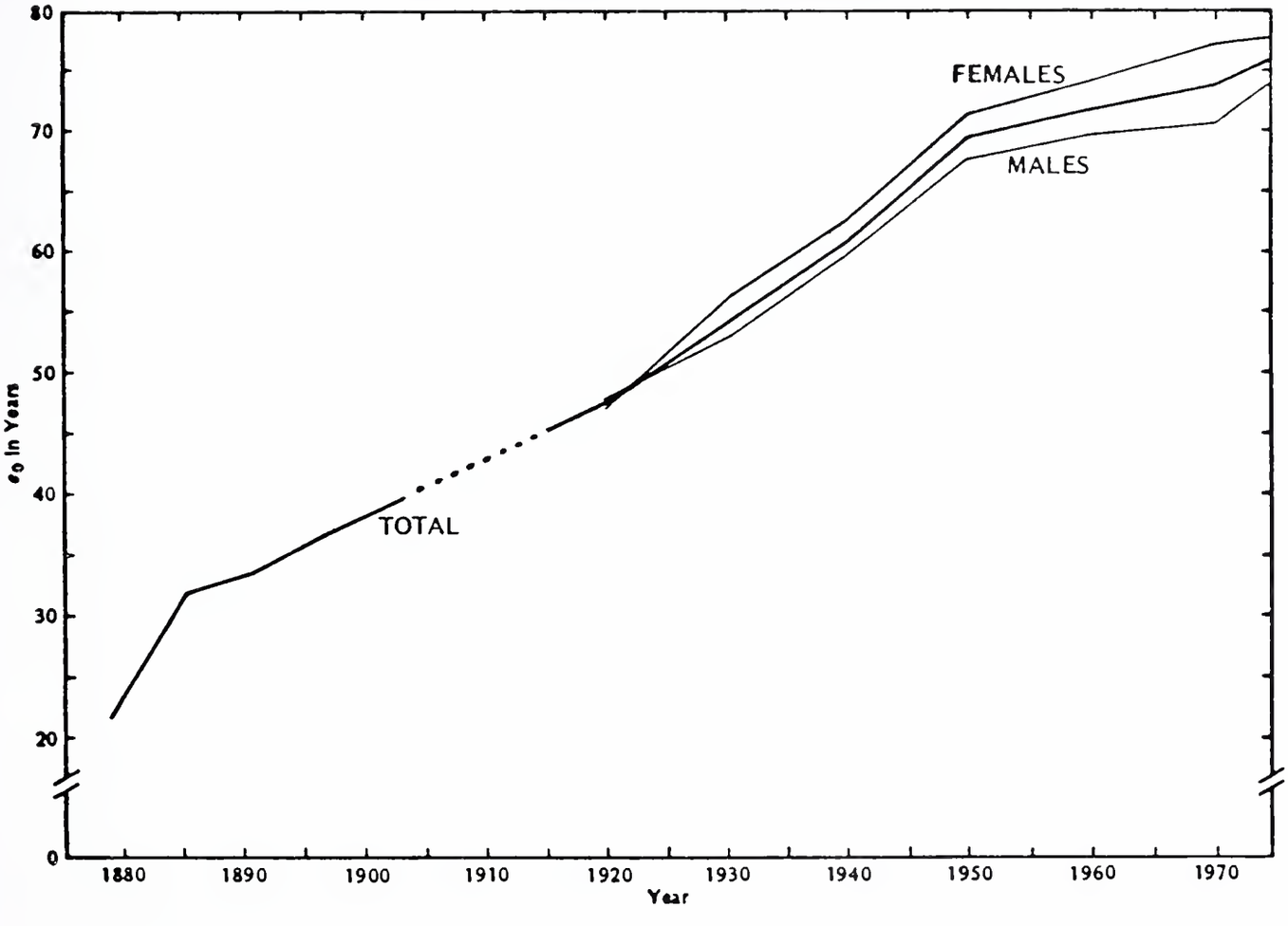
If the trend toward a slowing-down of the rate of mortality fall continues, there will be little further gain in life expectancy in Hawaii unless major new medical discoveries or techniques appear, or unless the importance of environmental and behavioral determinants of mortality, such

TABLE 1.—*Expectation of Life at Birth (e_0), Honolulu 1878-79 to 1894-98 and Hawaii, 1919-20 to 1975*

PERIOD (CENTRAL DATE)	MALE	$\bar{\Delta}$	FEMALE	$\bar{\Delta}$	COMBINED*	$\bar{\Delta}$	FEMALE MINUS MALE
			HONOLULU				
1878-1879 (1/1/79)					21.88		
						1.68	
1883-1886 (1/1/85)					31.95		
						0.28	
1889-1892 (1/1/91)				33.65			
						0.56	
1894-1898 (10/1/96)					36.89		
			HAWAII				
1919-1920 (1/1/20)	47.80		47.30		47.6		−0.50
		0.50		0.86		0.65	
1929-1931 (7/1/30)	53.09		56.28		54.4		3.19
		0.67		0.67		0.67	
1939-1940 (1/1/40)	59.46		62.60		60.8		3.14
		0.83		0.87		0.86	
1949-1951 (1/1/50)	67.76		71.27		69.4		3.51
		0.20		0.27		0.24	
1959-1961 (1/1/60)	69.79		74.01		71.8		4.22
		0.07		0.31		0.19	
1969-1971 (4/1/70)	70.46		77.18		73.7		6.72
		0.68		0.14		0.42	
1975 (7/1/75)	74.01		77.94		75.9		3.93

*Estimate based on proportions of males and females in the total actual populations.
$\bar{\Delta}$: the average annual gain in e_0.

FIG. 1.—*Expectation of Life at Birth (e_0), Honolulu and Hawaii, 1879-1975*



as stress and smoking, is lessened. Even such changes would have less effect than one might expect.[15]

2. The median age at death in the life-table population was calculated for each period. This seldom-seen measure can be used as a compan-

ion for e_0; changes and patterns of the median age at death parallel those of e_0 fairly closely. An advantage of the use of the median age is that it is not affected by the methodology used for closing the life table at the terminal age. On the other hand, when the value of l_x for the terminal age is greater than 50,000, as is the case for some recent tables, the median age at death is not easily found. The fact that the median age at death for the early periods, especially 1878-1879, is higher than e_0 makes these tables suspect, since experience with other life tables tells us that at low levels of e_0, the median age at death is even lower.

3. The sex differential in mortality, as shown by female e_0 minus male e_0, has grown steadily through 1970 (Table 1). There is some indication from the 1975 table that this trend has been reversed, but we must await the 1980 tables to be certain, especially since the history of almost all populations to this point in time is one of a constantly increasing differential in favor of females.[16] Hawaii's experience through 1970 is, thus, not unusual in this regard: whatever the bases of the sex-mortality differential, they have been operating here as elsewhere. Hawaii's differential in 1968-1971 was the lowest for any state,[17] mainly because males in this state have relatively low mortality compared to those in other states. (For detailed discussions of the sex-mortality differential, see reference no. 18.)

4. Probabilities of dying from one exact age (birthday) to another are presented in Table 2. The age distribution of mortality rates in Hawaii follows the usually observed pattern[19] from the earliest life table to the latest; mortality remains highest at the oldest and youngest ages. It is clear that, except for the childbearing ages in the early 20th century and probably before, female mortality has consistently been lower than male mortality at all ages. Table 2 illustrates that great falls in mortality have occurred at all ages; these falls are further examined in Table 3.

For the period 1885 to 1970, the fastest relative falls in mortality were at the ages under 30, a common pattern.[20] This was also true of the past half-century, but the age pattern of fall from 1885 to 1920 was irregular. (This may be due, in part at least, to the relatively poor quality of the data and to the change in geographical coverage.)

The value of a proportionate or relative fall in mortality, of course, is dependent on the magnitude of the base value. That is to say, at ages where ${}_nq_x$ values were already low, a small absolute change could lead to a large relative change. We can examine this further by looking at the

TABLE 2.—*Age-Specific Probabilities of Dying (${}_nq_x$) Honolulu, 1878-79 to 1894-98 and Hawaii, 1919-20 to 1975*

AGE			PROBABILITY OF DYING FROM EXACT AGE X TO EXACT AGE Y										
			HONOLULU				HAWAII						
X	Y	SEX	1879	1885	1891	1896	1920	1930	1940	1950	1960	1970	1975
0	5	Combined	.370	.269	.263	.243							
		Male					.149	.140	.066	.035	.029	.026	.019
		Female					.139	.106	.054	.026	.023	.019	.014
5	10	Combined	.079	.031	.045	.028							
		Male					.024	.012	.007	.003	.002	.002	.002
		Female					.023	.012	.006	.003	.002	.002	.001
10	20	Combined	.259	.134	.134	.092							
		Male					.052	.025	.016	.009	.007	.008	.006
		Female					.064	.016	.010	.006	.004	.004	.003
20	30	Combined	.250	.133	.137	.108							
		Male					.096	.042	.026	.015	.012	.014	.015
		Female					.123	.052	.027	.010	.007	.005	.006
30	40	Combined	.334	.193	.184	.175							
		Male					.108	.065	.047	.024	.017	.021	.018
		Female					.141	.066	.038	.018	.013	.015	.009
40	50	Combined	.265	.328	.246	.214							
		Male					.140	.111	.092	.052	.041	.046	.038
		Female					.133	.104	.066	.047	.032	.025	.025
50	60	Combined	.396	.466	.307	.302							
		Male					.217	.213	.168	.139	.113	.106	.087
		Female					.180	.165	.133	.094	.083	.064	.045
60	70	Combined	.671	.510	.422	.538							
		Male					.346	.360	.325	.268	.252	.232	.185
		Female					.341	.304	.258	.220	.167	.131	.116
70	80	Combined	NA	NA	NA	NA							
		Male					.598	NA	NA	.499	.462	.460	NA
		Female					.561	NA	NA	.424	.365	.312	NA

Note: Data by sex not available before 1920. Combined-sex tables not calculated for 1920-1975
NA—Not available

Note: For the tables beginning in 1919-1920, age data are available for ages 0, 1-4, 5-9, 10-14 and in five-year age groups thereafter. Because the earlier tables do not permit this level of detail, all data are presented in the broader groupings.

TABLE 3.—*Absolute and Relative Changes in Age-Specific Probabilities of Dying ($_nq_x$), Honolulu and Hawaii, Selected Periods*

INDEX*	CHANGE IN $_nq_x$ FROM 1885 TO 1970	1920 TO 1970 MALE	1920 TO 1970 FEMALE	1885 TO 1920	1879 to 1885
$_5q_0$	−.247	−.123	−.120	−.124	−.101
$_5q_5$	−.029	−.022	−.021	−.008	−.048
$_{10}q_{10}$	−.128	−.044	−.060	−.076	−.125
$_{10}q_{20}$	−.123	−.082	−.118	−.024	−.117
$_{10}q_{30}$	−.175	−.087	−.126	−.069	−.141
$_{10}q_{40}$	−.293	−.094	−.108	−.192	+.063
$_{10}q_{50}$	−.381	−.111	−.116	−.268	+.070
$_{10}q_{60}$	−.329	−.114	−.210	−.167	−.161

INDEX*	RATIO OF $_nq_x$ VALUES FOR 1970 TO 1885	1970 TO 1920 MALE	1970 TO 1920 FEMALE	1920 TO 1885	1885 to 1879
$_5q_0$	.084	.174	.137	.535	.727
$_5q_5$	.065	.083	.087	.758	.392
$_{10}q_{10}$	.045	.154	.063	.433	.517
$_{10}q_{20}$	.071	.146	.041	.823	.532
$_{10}q_{30}$	.093	.194	.106	.645	.578
$_{10}q_{40}$	.108	.329	.188	.419	1.238
$_{10}q_{50}$	.182	.488	.356	.426	1.777
$_{10}q_{60}$	.356	.671	.384	.674	.760

*$_nq_x$ is the probability of dying in the n years following the xth birthday.
Note: Simple average of male and female $_nq_x$'s used when necessary to have a combined value.

absolute changes in $_nq_x$ (Table 3). Here, the largest changes occur at the ages where the original levels are highest, i.e. where the possible changes are the greatest: the youngest and oldest ages.

These patterns of change are not unusual. Preston[21] notes that "mortality improvements, when measured by the absolute decline in age-specific rates, have tended to be the largest at ages under 5 (especially infancy) and over 40. The proportionate declines on the other hand have been largest in the older childhood ages . . . In these matters, mortality experience in the less-developed countries has roughly recapitulated that in more-developed countries."

Conclusions

What can be concluded, then, about rates of change at the different ages? First, Hawaii's experience is similar to that which has been almost universally observed elsewhere. Second, rapid falls have occurred at all ages, but not equally and not at the same pace or relationship over different periods. Finally, since 1885, the greatest absolute falls in $_nq_x$ values have been made at the extreme ages, but the lowest probabilities of death are still at ages 5-10 and 10-20. The probabilities have been converging, as the lowest rates approach zero.

Summary

Mortality in Hawaii has reached extremely low levels and may be at a plateau. A baby girl born here in 1975 and living here under unchanging 1975 mortality conditions would have an expected life of almost 78 years, while a baby boy would live about 74 years. These values are probably the highest in the United States and are among the highest in the world. (In 1969-1971, a ranking of the states showed Hawaii 1st, Minnesota 2nd, and Utah 3rd. Only Norway and Sweden appear to have had higher values for e_0.[22]) The probability of dying is extremely low at ages 1-15, highest at the oldest ages. Female mortality at all ages is lower than that for males, but it is not yet certain if this gap is widening or beginning to lessen.

In general, there is no sign that the levels and patterns of change of mortality in Hawaii have been significantly different from those observed elsewhere.

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Vanishing Bone Disease: A Case Report

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• *Spontaneous bone dissolution was first reported by Jackson in the* Boston Medical and Surgical Journal *in 1838*[1] *and 1872.*[2] *Since then, many case reports have been published in the* Journal of Bone and Joint Surgery *under various titles, such as disappearing bone disease, massive osteolysis, vanishing bone disease, phantom bone, or essential osteolysis. In 1954, Gorham, Wright, Schultz, and Maxon*[3] *described the pathology; since then, the condition has also been called Gorham's syndrome.*[4]

Up to 1955, 24 cases were traced by Gorham and Stout,[5] and by 1964, Gorham and West had unearthed 49 reported cases. "About 50" were counted by Caulet et al. in 1968.[6] As of today, there are about 60 reported cases. This present case report, the first one in Hawaii, is probably the 61st.

Case Reports

A 51-year-old Japanese plumber, in good health until May, 1972, presented with a 4-month history of left-sided posterior chest pain, aggravated by movement. He denied loss of weight or chronic cough. Physical examination revealed a hand-sized defect with complete softening of the chest wall overlying the 9 and 10 ribs. Lungs were clear to auscultation. X-ray examination revealed a destructive lesion of the left 9 and 10 ribs. Intravenous pyelogram, upper gastrointestinal series, barium enema, and gallbaldder series were all negative.

All other laboratory investigations failed to reveal any underlying primary metabolic or other condition which could have initiated or explained the bone resorption.

Open excision biopsy of the affected ribs showed osteoporosis with para-osseous angiofibrosis and focal regenerative osteoplasia, findings compatible with what has previously been reported as "disappearing bone disease."

Follow-up chest x-rays in the clinics showed complete resolution of the previously noted pleural effusion.

He did well until 2 years later, May, 1974, when he was seen with complaints of pain in the left hip, accompanied by swelling of the flank and left thigh. Swelling extended below the level of the costal margin and extended down to involve the iliac crest. X-rays showed destruction and disappearance of the iliac crest for around a quarter of its mass. Biopsy did not reveal any significant findings, nor did a repeated extentive work-up. Chest x-rays showed no abnormality except for the absence of the 9 and 10 ribs. Intravenous pyelogram was normal. On bone scan,

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there was decreased uptake only in portions of the affected left iliac bone.

Exploration revealed a diffuse, soft, grayish-white tissue, with a spongy network and yellowish turbid fluid exuding from the cut surface. Profuse bleeding was encountered. The area involved extended beneath subcutaneous tissue, sparing the skin itself, and ranged from the level of the left 10 rib area down to an inch below the iliac crest. The lesion did not penetrate the peritoneal cavity; it followed the fascial planes of the external and iliac vasculature. The iliac bone itself showed no irregularities and the area where it had been eroded showed a smooth edge.

Frozen section as well as permanent sections showed idiopathic osteolysis of the bone, due to proliferation of a spongy network of soft tissue composed of vascular channels.

The area involved was quite extensive and was not resectable. Hence, the patient underwent radiotherapy to the lesion to control further spread of the process.

After 2 months, he sought hospital readmission for severe left-sided chest pain and respiratory distress of sudden onset. Examination showed erythematous swelling of the left chest as well as of the abdominal wall, down to the thigh. There was fullness and tenderness on palpation. Chest x-ray showed pleural effusion of one-third of the left lung base, with possible pericardial effusion. Thoracentesis revealed a transudate but not malignant cells. He deteriorated and subsequently expired of cardiorespiratory failure.

Discussion

Massive osteolysis characterized by complete destruction of all or part of bone by angiomatous tissue is only one of four varieties of unrelated conditions implied by the word "osteolysis."

There are 4 types of "osteolysis" as described in literature, namely:

1. Idiopathic osteolysis affecting carpal and tarsal bones. This condition is present in childhood and inherited as an autosomal dominant disorder. There is no evidence of angioma, or renal disease, and the condition poses no threat to life (Torg and Steel, 1968).[7]
2. Idiopathic osteolysis with nephropathy affecting carpal, tarsal, and adjacent tubular bones of young children, who develop hypertension and azotemia and die in early adult life. There is no evidence of angiomatosis and the condition is not inherited.
3. Hemangiomatosis with massive osteolysis (Fornasier, 1970),[8] characterized by extensive congenital proliferation of blood vessels, affecting skin, subcutaneous tissues and muscles as well as bone. Condition may affect an entire limb, with disappearance of bone.
4. Massive osteolysis, characterized by complete destruction of all or part of bone by angiomatous tissue. The process may spread insidiously, like a locally invasive tumor, involving adjacent bones and soft tissue. It may cause death by encroaching on vital structures. Spontaneous arrest of the condition has been reported. This type is not inherited and is not congenital. This case report is an example of this fourth type.

Clinical Features

Massive osteolysis occurs predominantly in children or young adults. In fact, the first case report is that of an 18-year-old man whose humerus disappeared completely in the course of 11 years. He sustained spontaneous fractures twice. Inspite of the abnormality, he was able to work until he died at the age of 70 years. A case report in 1970 was of a 12-year-old girl[9] and another was of a 10-year-old girl, who died at age 36. However, isolated cases have been reported as old as 59.[8] There is no significant sex predilection in reported cases. No evidence of genetic transmission has yet come to light.

Localized pain is the usual presenting symptom. There may be a history of a mild injury. Physical examination reveals tenderness of the involved area without signs of systemic disturbance. There may be signs of soft tissue swelling without evidence of inflammation, and overlying skin remains normal.

Johnson and McClure (1958)[10] relate frequency of massive osteolysis in different bones, the sequence being: clavicle, scapula, proximal end of the humerus, ribs, iliac bone, ischium, and sacrum. The disease has not been observed in the calvarium except in the case of an 11-year-old girl, reported in 1974.[14] Distal bones of the extremities have not been involved to date.

Pathology

According to Gorham and Stout, the most characteristic histologic abnormality in massive osteolysis is change of bone into soft connective tissue, containing many thin-walled blood vessels, sometimes with red blood cells. Others show freely anastomosing vascular spaces lined by endothelial cells. Lymphatic channels are not involved. Abnormal blood vessels infiltrate skin, subcutaneous tissue, underlying soft tissue and bones.

Johnson and McClure (1958) distinguished 2 stages in the process of massive osteolysis. Proliferation of capillaries in the endosteal connective tissue is characteristic of the first stage. The later stage shows replacement of bone tissue by fibrous tissue. Avascularity is said to be rare.

The microscopic picture of our case showed intertrabecular spaces containing loose-textured

adipose tissue with a few islets of hematopoietic cells, eosinophils and plasma cells predominating. One section showed pronounced thickening of periosteum by dense fibrous tissue overlying an irregular bony surface; another section showed fibrous tissue with many dilated thin-walled blood vessels and several anastomotic trabeculae of osteoid tissue.

On reviewing previously reported cases and this present case, massive osteolysis is probably best regarded as a locally aggressive, destructive tumor of blood vessels with a slow progression. Unless the process involves essential parts of the skeleton, such as thoracic cage, eventual arrest may be expected. It may cause death by encroachment upon adjacent vital structures.

Treatment

The best method of treatment is difficult to determine. Results of surgical treatment, consisting of amputation and local resection, with or without replacement prostheses or bone grafts, are variable. Sympathectomy has been done without benefit. Results from radiotherapy have been equivocal. Two cases of arrest of disease have been reported by Johnson and McClure. In the present case, radiotherapy was given to arrest the spread of the disease. Unfortunately, post-radiation complications took their toll.

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Editorials

AMA Is Active In Effort To Cut Federal Regulation Down To Size

To what extent does glamorized federal planning boil down to sheer regulation? And to what extent does the regulation lead to costly irregularities?

These are questions with which the American Medical Association must constantly grapple, in numerous situations and respects. And various irregularities have been cited by units of the government itself—alongside the pressure for a greater federal role in health.

Consider these examples:

• Legislation has been introduced in Congress—by Rep. Tim Lee Carter, a physician—to keep Food and Drug Administration regulations from overly delaying the approval of new drugs that could benefit patients both medically and economically.

• The General Accounting Office—federal budgetary watchdog—has complained that HEW-funded neighborhood health centers are not reaching most of America's medically underserved, and that HEW has not made sure the centers are put in the neediest areas.

• The GAO has also complained of defects in HEW's Health Maintenance Organization program, including an "ineffective" record in administering and monitoring the loans for HMOs.

• A number of local Health Systems Agencies under the Health Planning Act have protested HEW's guidelines for implementing the act—partly on the ground that these supersede, and thus duplicate in cost, the guidelines that HSAs have been developing.

HEW, according to a recent Associated Press story, misspent more than $5 billion in fiscal 1977 and blames waste and mismanagement more than fraud and abuse.

Yet, does that estimate—whopping as it is—give the full picture of health expenditure gone astray? What about the cost of supplanting those HSA guidelines? And what about the $5,000 to $20,000 (depending on the project involved) that applicants for a certificate of need must spend on its processing under the Health Planning Act?

In health and other fields, "the sum of the administrative costs of federal regulation (paid by the taxpayer) and the compliance costs (generally passed on to the consumer in the form of higher prices) may top $100 billion" for fiscal 1979, says Murray L. Weidenbaum, director of the Center for the Study of American Business at Washington University, St. Louis, and a former federal official.

That $100 billion is where supposedly idealistic planning can lead.

Well, what are some of the things the AMA has been doing about the examples and problems given above?

• The AMA developed the anti-drug-delay bill introduced by Kentucky Congressman Carter.

• It is a cosponsor of a Robert Wood Johnson program to improve medical services in the inner cities of Baltimore, Cincinnati, Milwaukee, St. Louis, and San Jose.

• The AMA House of Delegates in June approved "in principle" a National Commission on the Cost of Medical Care recommendation calling in part for "fair market competition between HMOs and other provider and insurance systems."

• The AMA supports Health Planning Act amendments to make HSAs more independent in their guidelines and operations.

• It backs the proposed Sunset Act that would require regulatory agencies and programs to justify their right to eternity and make them more accountable to Congress.

The Association is so energetic in so many areas of activity that some physicians may be confused as to just what it does. But the $250 regular dues are spent as soundly and effectively as possible for the benefit of all physicians and patients—and every doctor should know or be told.

Education of the Patient

"Doctor, my daughter has a severe headache and she's crying. Shall I take her to the hospital?"

"Let's see now. All your daughters are grown. How old is this one?" counters the family physician in answer to the late evening phone call from a harried mother.

"She's twenty; she's been out all day in the sun with her boyfriend," came the reply.

"Has she taken anything for it?"

"No. Might she have a brain tumor, doctor? Should we get some X-rays?"

And so it went. After several more phone calls occasioned first by vomiting of undigested fastfoods and then by hyperventilation, things quieted down.

Several days later, the physician recognized the mother coming out of the hospital ER, this time with another "adult" daughter in tow. "How did it go with Tanya the other night?" he asked, "and what are you doing here with Sonya today?"

"Oh, Tanya was fine and went to sleep after breathing into the paper bag, as you suggested. I didn't want to bother you about Sonya, since this is Sunday. She has the hives, and the emergency room doctors here took care of it."

The cost to that family for Tanya was nil. It took the doctor's time, to be sure, and since he was that family's primary care physician of long standing, he knew with what elements he was dealing. He knew the mother to be one to go into a panic over the least little medical thing; who considered her offspring, though adult, still to be her "babies." Despite their long association in the physician/patient relationship and his invariable patience, each visit, in the education-of-the-patient process in health care, Mama had never fully grasped anatomy and physiology; nor had she comprehended the normal functions of her own body—much less understood what might happen to it in times of disease, injury or plain aging. What's more, neither did any of her well-educated, modern-times children know any more about themselves, current curricula of our school systems being as they are. To Mama's credit, however, she had been taught, or had learned enough to have phoned her PMD *first!* Most physicians consider such phone calls as part of their obligation to teach, to advise and to "educate" their patients—for free.

And yet, not having learned her lesson, seemingly, Mama rushes off a few days later and runs up a huge dollar expense at the ER on behalf of Sonya for a minor event. This was an "emergency," by her definition; no ER dare assert a contrary one. The dollar expense at the ER may well have exceeded by three or four times what a visit to her PMD's office, much less a simple phone call to him, might have cost, considering that the hospital has a right to make an across-the-threshold charge, and the ER physician a charge for his services.

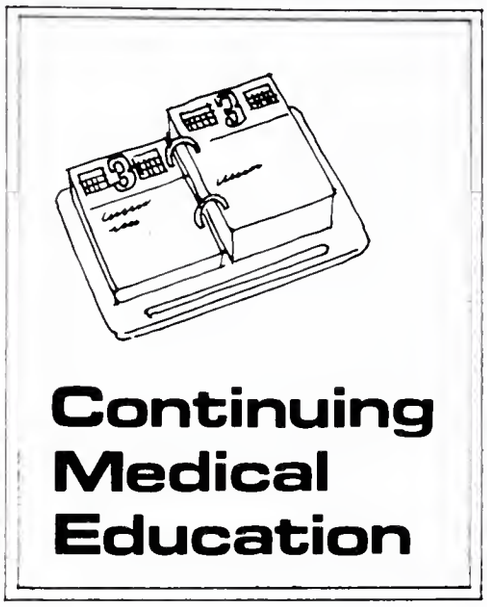
The American Academy of Family Physicians' Congress of Delegates, at its annual meeting in San Francisco in September, came out strongly against DHEW's emphasis on "cost containment," which everyone knows equates with "reduction of benefits." The A.A.F.P., instead, came up with two new catch phrases: "Cost awareness" and "cost effectiveness." The Congress of Delegates adopted these as principles in an emerging intensification of effort directed at education of the patient.

"Oh, but my medical plan (insurance) will cover this visit to the ER, doctor," says Mama, on being chided for seeking such expensive care. The cost/benefit ratio of that visit is obviously high; "cost effectiveness," by this example, illustrates what this nation does face and must resolve. It should be easily apparent that pre-paid medical insurance coverage aggravates the problem.

The bedrock basis for a solution to holding or reducing health care costs is education of the patient, starting with the acquisition of knowledge of self in health and disease in grades K and 1 and repeated each year through grade-school, highschool and college. Cost effectiveness and cost awareness should follow naturally.

Individual physicians in private practice can and should be asked to participate together with their colleagues in academia in this process. Meanwhile, individual physicians in active practice can stem the tide by increasing their efforts at "patient education" in their own offices. The national effort, on the other hand, should be directed through the school systems. It will take a generation before this proposal can be evaluated, however, and there are many who are as deeply concerned with the problem who believe that human beings are uneducable!

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/ Maui Mem. Hsp.

John A. Burns School of Medicine

1. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
2. U.H. Cardiology Grnd. Rnds., 1st & 3rd Tuesday, 5:30 p.m. Rm. 506 Univ. Tower, Queen's.
3. UH Grand Rnds-Ob/Gyn, Wed. 7:30-8:30 a.m. Kapiolani Hsp. Aud.

4. UH Perinatal Conf., Thurs. 3:30-4:30 p.m. Kapiolani Hsp. Rm. 815.
5. UH Seminar, 2:30-3:30 p.m. Kapiolani Hsp. Rm. 826. Fridays, 1st-Pathology; 2nd-Perinatology; 4th-Journal Club.
6. UH Conf., Friday, 3:30-4:40 p.m. Kapiolani Rm. 826.
7. Psychiatry Grand Rounds, 1½ hours credit, Friday 8:00 a.m.-9:30 a.m. University Tower, 6th Floor, 1356 Lusitana Street. Contact: Dr. McDermott at 548-3420.
8. Psychiatry Case Conference, 1½ hours credit, Tuesdays 10:00-11:30 a.m. University Tower, 4th Floor, 1356 Lusitana Street. Contact Dr. McDermott at 548-3420 or Dr. Wen-Shing Tseng.
9. University Medical School Grand Rounds, 3rd Thursday, 4:30-6:00 p.m.
 11/16/78—"Endomorphins, pain and drug dependence." Coordinator: Dr. Richard Markoff. Art Building, UH Manoa.
 12/21/78—"Hanson's Disease." Coordinator: Olaf Skinsness. Mabel Smyth Auditorium.

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Kapiolani Maternity Hospital

1. Tuesday Conference, 1:00-2:00 p.m. Kapiolani Hsp. Aud.
 1st—Didactic Presentation
 2nd—Perinatal-Neonatal Topics
 3rd—Obstetrics Topics
 4th—Gyn Topics
2. Neonatal Grand Rnds., Friday 8:00-9:00 a.m. Kapiolani Hsp. Nursery.
3. Tumor Board-Oncology Conf., 1st & 3rd Friday, 1:00-2:00 p.m. Kapiolani Hsp. Aud.

Kuakini Medical Center

1. Visiting Professor Program
2. G.I. Conference, 4th Tuesday, 8:00-9:00 a.m.
3. Nephrology Conference, 4th Wednesday, every month, 8:00-9:00 a.m.
4. Oncology Conference, every Thursday, 7:30-8:30 a.m.
5. Surgical Conference, 2nd and 3rd Friday, 1:00-2:00 p.m.
6. Surgical Mortality and Morbidity Conference, 4th Friday, 1:00-2:00 p.m.
7. Opthalmology Departmental Meeting, 1st Tuesday, every month, 1:00-2:00 p.m.
8. Medical Mortality & Morbidity Conference, 4th Tuesday, every month, 1:00-2:00 p.m.)

(Contact CME Dept.-Kuakini for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
6. SFH-UH Surg. Sat. Teaching Rnds. (except 4th) 7:30-8:30 a.m. UH 4 Classroom.
7. SFH-UH Hematology Conf., 4th Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
8. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
9. Tumor Conf., ea. Monday, 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Cardiac Surgery Meeting meets the 2nd Tuesday of the month, from 4:30-5:30 p.m. in the Doctor's Dining Room.
3. Friday Noon Conference meets weekly, from 12:30-1:30 p.m., in the Doctor's Dining Room.
4. Medical Grand Rounds meets the 1st Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.
5. Orthopedic Conference meets quarterly, from 7:30-9:00 p.m., in the Doctor's Dining Room.
6. Quarterly Professional Meeting meets the 4th Monday of the month, from 7:30-8:30 p.m., in the Doctor's Dining Room.
7. Surgical Mortality and Morbidity meets the 4th Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday

2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Montbly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Local Hospitals, Honolulu
Type: 1, 1 hr./day, 1 day/mo. from 12 mos.
Fee: None Methods: AV, O, Pan
Dates: All yr., 12 hrs. instruction

SPECIAL EVENTS

Nov. 14-15, 1978	Temperament: A New Understanding of Individuals in Interaction. Col. of Hlth. Sci. & Soc. Welfare-U.H. Col. of Con. Ed. & Comm. Serv. Halekoa Htl, Waikiki-9:00 a.m.-4:00 p.m.
also on Nov. 20-21	UH-Hilo, Campus Center 9:00 a.m.-4:00 p.m. 12 hours Cat. I CME. Contact: (Manoa) 948-8581 or (Hilo) 961-9555 or 961-9354.
Nov. 28, 1978	Today's Teenagers: Tbeir Problems & Promise—HMA/HCMS Aux. 8:30 a.m.—4:00 p.m. Cat. 1—7½ hrs. Ala Moana Americana Htl. Hibiscus Ballroom. Contact: Mrs. Elisabeth Bell, 732-3074 or Mrs. Nancy Simmons, 533-6331.
Nov. 29-Dec. 1, 1978	Hospice-A Humane Alternative; Hsp. Home Hlth Care/HMA. 8:30 a.m.-12:00 p.m. & 9:00 a.m.-4:00 p.m.; 9:00 a.m.-2:30 p.m. Hyatt Regency Waikiki, Honolulu. Cat. 1—9 brs. Hospice Hsp. Home Hlth. Care Agen. of Calif., 23228 Hawthorne Blvd., Torrance, CA 90505.
Dec. 6-7-8-9, 1978	Am. Med. Joggers Assoc. 16 hours Cat. 1. Contact: Kent Davenport, M.D. or Honolulu Marathon Assoc., P.O. Box 27244, Chinatown Station Honolulu, 96827.
Jan. 4-6, 1979	Maternal & Fetal Med. Am. Coll of Obstetricians & Gyns., 1 E Wacker Dr., Chicago 60601. At: Island of Hawaii. 2½ days, 16 hrs.
Jan. 8-12, 1979	Echocardiography: A Review of Current Concepts & Techniques. Am. Coll of Cardiology, 9111 Old Georgetown Rd., Bethesda, MD 20014. Cosponsor-U of H John A. Burns Schl of Med., The Honolulu Med. Group Research Found. Held at Wailea Beach Htl., Wailea, Maui. 5 days, 20 brs.
Jan. 15-17, 1979	Urology for Specialists, Univ. of Ore Hlth Sciences Ctr., Div of Cont Med Educ, 3181 SW Sam Jackson Pk. Rd., Portland, OR 97201. Held at: King Kamehameha Htl., Kailua-Kona, HI. 3 days, 16½ hrs.
Jan. 20-27, 1979	Adv. in Nephrology, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave. LA, CA 90033. Held: Intercontinental Htl, Maui. 5 days, 30 hrs.
Jan. 22-28, 1979	4th Annual HI Hosp. Med. Staff Conf. Estes Park Inst., Box 400, Englewood, CO 80151. Cosponsor: Queen's Med. Cntr. Held at Kauai Surf Resort, Kalapaki Beach, Kauai 96766. 5 days, 30 hrs.
Feb. 1979	Workland Recording Workshops, Coll of Am. Pathologists, 7400 N. Skokie, IL 60077. Held at Sheraton Waikiki, Honolulu. 15 hrs.
Feb. 6-9, 1979	Perinatal Med. USC Sch. of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Royal Lahaina, Maui. 5 days, 19¼ brs.
Feb. 19-22, 1979	Mid-Winter Traveling Med. Educ. Course, Kansas City SW Clin. Soc., 2220 Holmes, KC, MO 64108. Cosponsor: U of MO-Kansas City Sch. of Med. Held at Maui Surf Htl., Maui. 4 days, 16 hrs.
Feb. 19-25, 1979	Financial Planning/Med & Dental Prac Management, Med Communications & Servs Assn. 1107 NE 45th, S 315, Seattle, WA 98105. Held at: Sberaton-Molokai, Box 1977, Kepuhi Beach, Maunaloa, Molokai.
Feb. 26-Mar. 2, 1979	Surg. Diag. & Therapy, The Phil Thorek Postgrad. Courses, 850 Irving Park Rd., Cbicago 60613. Held at Maui. 5 days.
Mar. 6-10, 1979	U of H Sports Med. Course, Schl. of Med. 1960 E-W Rd., Honolulu, 96822. Cosponsor: AAFP. Held at Princess Kaiulani Htl. Waikiki, Honolulu. 5 days, 18 hrs.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



Friday, August 4, 1978, 5:30 p.m.
HMA Conference Room

PRESENT

Drs. M. Hanlon, G. Goto, C. Sia, D. Bell, W. Hindle, H. Chinn, W. Iaconetti, G. Mills, R. Stodd, J. Williams, R. Lichter, C. Kam, J. Edwards, A. Siemsen, L. Howard, A. Roth, F. Lafferty, D. Fu, A. Wigle, and A. Catts. Also present were Mrs. B. Yim, Mr. O. Chikamoto, and staff members J. Won, L. Ajifu, B. Chang, B. Kendro, N. Ontai, T. Leineweber, and C. Young.

CALL TO ORDER

The meeting was called to order by President Marion Hanlon.

MINUTES

The minutes of the meeting of July 7, 1978 were approved as circulated.

REPORT OF THE TREASURER

A. The June financial statement was reviewed in detail and approved subject to audit.

B. Legal Fees: Two invoices for legal services rendered in connection with the HNA suit and the termination of the tripartitie Mabel Smyth Building agreement were approved for payment.

C. Building/Parking: Mr. Won noted the increasing problems encountered in keeping the HMA parking lots open for physician's use. It was recommended that a part-time attendant be hired.

ACTION:

It was voted to refer the recommendation to the Executive Committee.

D. PEC: The Medical Education Committee recommends printing of the HMA's Physician's Education Certificate. The PEC will be available to physicians who complete 50 hours of CME in a one-year period. The printing of 2,500 brochures, forms, and certificates is expected to cost $900.

ACTION:

It was voted to proceed with the printing of the PEC.

E. Oahu Health Services Directory: It was recommended that this 5-volume directory be purchased ($22) for HMA's Reference Library. The recommendation was approved.

F. Student rate for HMJournal: The HMA Publications Committee recommends a special student subscription of $6.00 per year. The Council deferred action on this item and asked for a breakdown of actual costs including postage.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. EMS: Dr. Livingston Wong presented a report to the Council for Dr. Dang, outlining the various problems related to the state appropriation to the EMS program. He noted that the allotment to the Department of Health was 2.3% less than the legislative appropriation and that all programs in the DOH are affected. There were questions regarding the legislation enacted and how the funds are to be channeled.

ACTION:

A motion was made and seconded that the HMA President meet with the Director of Health and the Governor to work out the EMS contract. The motion was amended to include Dr. Wong and Dr. Dang in the meeting. The amended motion was passed.

Dr. Goto reported that the ad hoc committee on the EMS organization which met on August 2, 1978, proposes the following:

(1) Formally dissolve the current organizational structure of the EMS Executive Committee;

(2) Establish an EMS Advisory Committee which shall be advisory to the Project Director and to the Council;

(3) The Project Director shall exercise professional and administrative control over the HMA-EMS program. The Project Director may, at his discretion, refer administrative duties to the HMA administrative structure under the HMA Executive Director.

A motion was made and seconded to adopt the proposal as circulated. In the discussion on Item 1, it was noted that the nature of the EMS program frequently requires immediate action and it was felt that the present EMS Executive Committee could meet those needs. The motion to approve Item 1 was defeated. In view of the action on Item 1, it was agreed that the status of the present EMS Executive Committee would stand. A substitute motion for Item 3 of the proposal was moved and seconded that the project director of the EMS program be responsible to the Executive Committee (EMS) and that the Executive Committee be responsible to the HMA Council. The Executive Committee would include the chairman and two members from the HMA, a representative of the Hospital Association and a representative of the Department of Health. The motion was tabled until the next meeting to clarify the status of non-members on HMA committees.

B. RVS: Dr Hanlon noted that a letter from Dr. Mills regarding an update on the national status of RVS would be sent to the Fee Survey Committee for comments to the Council.

C. Cost Containment: Dr. Mills summarized the status of legislation which would limit the rate of increase in hospital rates. The Council congratulated Dr. Mills on his appointment as Chairman of Hawaii's Voluntary Cost Containment Committee. A copy of the speech of the incoming AMA president, Dr. Tom Nesbitt, was circulated for Council perusal.

D. Cancer Center: It was reported that the Core Grant for the Cancer Center was approved by NCI.

E. Communicable Disease Committee: Dr. Fu reported that the committee is again considering the question of rubella testing with premarital exams. The committee will meet in a few weeks to continue discussions.

F. SHPDA: Dr. Sia reviewed the structure of the State Health Planning and Development Agency and noted the need for physician involvement in the seven task forces which are working on the various implementation plans.

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G. Health Manpower: It was noted that there is a growing trend to utilize physician's assistants in long term care facilities. It was recommended that the HMA Manpower Committee review the HMA position on manpower.

UNFINISHED BUSINESS

A. Dr. Hanlon announced that Dr. N. Bruce accepted the position of Director of CME for a three month period.

B. Dr. Hanlon reported that he attended the Kennedy/AMA Conference on Positive Health Strategies in Washington, D.C.

C. A copy of HMA's position statement in response to President Carter's principles on National Health Insurance was circulated for Council perusal.

D. Dr. Hanlon noted that Rep. Herbert Segawa wrote to HMA as an outcome of the 9% Solution Conference and requests information regarding physician attitudes.

NEW BUSINESS

A. Staff retreat: Mr. Won reported that HMA executive staff plans to hold a staff retreat on Saturday, August 26, to review administrative priorities in the HMA.

ACTION:

It was voted to appropriate $100 for the retreat.

B. Insurance: HMA Council requested a report on the status of the self-insurance company at the next Council meeting.

The meeting adjourned at 9:30 p.m.

DOUGLAS B. BELL II, M.D.
Secretary

"We Bring People Together"

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Sincerely,

Paul S. Isenburg, Ph.D.
Director
Medical Division

1441 Kapiolani Blvd./Suite 1203, Honolulu, Hawaii 96814/Phone 955-6686



New Members



Stephen D. Arnold, M.D.

888 South King Street
Honolulu, Hawaii 96813

INTERNAL MEDICINE



Russell D. Hicks, M.D.

2230 Liliha Street
Honolulu, Hawaii 96817

INTERNAL MEDICINE



Michael Ishioka, M.D.

1481 South King Street
Honolulu, Hawaii 96814

INTERNAL MEDICINE



Louis S. Morgan, M.D.

888 South King Street
Honolulu, Hawaii 96813

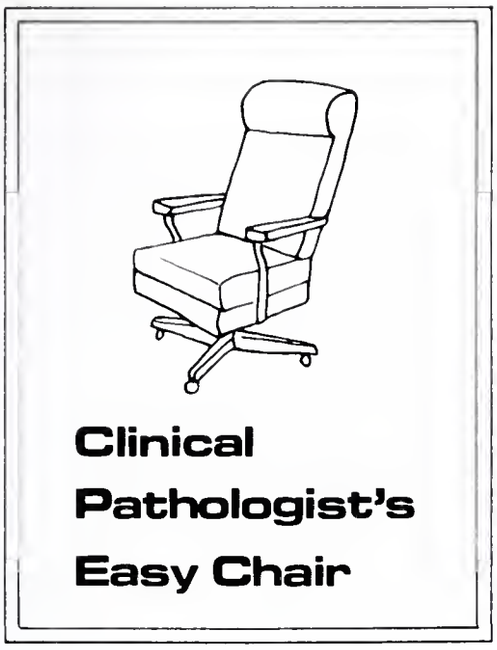
DERMATOLOGY



Jinichi Tokeshi, M.D.

1451 South King Street
Honolulu, Hawaii 96814

FAMILY PRACTICE



Clinical Pathologist's Easy Chair

FRANCIS FURUNAGA, M.D.

Creatine Phosphokinase Isoenzymes

Creatine phosphokinase (CPK) is an enzyme found in brain, skeletal and cardiac muscle, small amounts being in the thyroid, prostate, kidneys, lungs, spleen and the G.I. tract. Elevated serum activity reflects tissue injury with cell breakdown and release of the enzyme into the blood stream. It is increased in a variety of conditions, including myocardial infarction, acute myocarditis, pulmonary thrombosis, CVA, polymyositis, muscular dystrophy, pancreatitis, hypothyroidism, shock, operative trauma, convulsions, intramuscular injections, following electrical cardioversion, hypokalemia, after strenuous exercise, clofibrate therapy and chronic alcoholism. There may be significant racial differences, as shown by higher levels in blacks than in whites.

Total CPK can be fractionated into three isoenzymes—MM, MB and BB. MM is the predominant isoenzyme in normal serum, and is found in skeletal and cardiac muscle, with smaller amounts in the lungs and brain. BB is found mainly in the brain, but usually not in the blood except in malignant hyperthermia, and in renal disease patients (about 45%) under dialysis therapy, and in some cases of metastatic gastric carcinoma.[1,2] MB is found predominantly in cardiac muscle, with a small amount (about 2%) in skeletal muscle and virtually none in other organs.

The MB isoenzyme makes up about 15 to 20% and MM the remainder of the total cardiac muscle CPK. The MB fraction appears rapidly following a myocardial infarction, usually in 2 to 8 hours, peaks at about 24 hours, rapidly decreases after 36 hours, and disappears by 48 to 72 hours. The optimal time for detection is 12 to 24 hours after the infarction. Absence of the MB fraction within 24 hours after the onset of symptoms excludes the diagnosis of a myocardial infarction.[3]

Determination of CPK isoenzymes is especially useful when sources other than the myocardium may contribute to the total CPK activity, such as in postoperative patients and after intramuscular injections, and also to determine extension of a myocardial infarct, and to detect myocardial injury in patients undergoing coronary by-pass surgery.[4] The persistence of the MB fraction cannot be regarded as diagnostic of myocardial infarction, although it is specific for myocardial necrosis. Persistent levels may be present in patients with permanent pacemakers, following external cardiac massage with or without intracardiac puncture, chronic atrial fibrillation, congestive heart failure or cardiomyopathy.[5,6] Elevated MB activity has been reported in some patients with hypothyroidism, Duchenne's muscular dystrophy, polymyositis and dermatomyositis, malignant hyperthermia and carbon monoxide poisoning, but none of these cases should cause any difficulty in the evaluation of a suspected myocardial infarction.[7]

The combined use of CPK and LDH isoenzymes is believed to provide the best laboratory aids in the diagnosis of a myocardial infarction. The MB isoenzyme and the fast moving LDH fractions are elevated with a higher LDH-1 than LDH-2 (flipped LDH pattern). Some authors feel that only the presence or absence of the MB fraction is clinically significant,[5] while others believe that 3% should be the upper limit of normal.

There are 3 basic methods for the determination of the CPK isoenzymes. Electrophoresis is the reference method and shows superior resolution and reliability but requires more skill, while ion exchange column chromatographic methods require less skill and show greater sensitivity.[8] The MB fraction in the column method often overflows into the BB, but this problem is usually only academic since BB is hardly ever found in blood. However, elevated BB activity in renal failure patients and patients with atypical MM would give falsely elevated MB activity by this procedure.[9] Selective activation of the MB fraction with dithiothreitol is the simplest but least satisfactory method, because of frequent falsely elevated MB especially with high total CPK activity.

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1. Galen RS: Creatine Kinase Isoenzyme BB in serum of renal-disease patients, *Clin Chem* 22:120, 1976.
2. Lederer WH, Gerstbrein HL: Creatine kinase isoenzyme BB activity serum of a patient with gastric cancer, *Clin Chem* 22:1748-1749, 1976.
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"No problem with the oil change and lube, but it keeps rejecting the new oil filter."

Hawaii Academy of Family Physicians' Newsletter

J. I. Frederick Reppun, M.D.

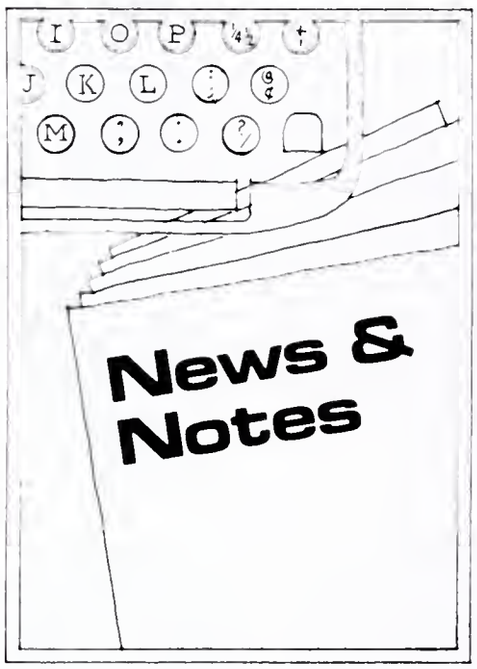
New Members—We welcome to our chapter **Judith A. Hartner MD** as an Active member and **Marcia E. Sablan MD** as a Resident Affiliate.

Dropped—alas, for one reason or another, are **Barnett, Baysa** (Jeff) and **Yano,** students who graduated from UHSM this year with their MD degrees but who chose not to apply for continued membership. Also graduating this year from UHSM was **Sandra Penn MD,** who has continued her membership in AAFP by applying as a transfer to the New Mexico AFP. Student members, upon graduation, MUST reapply if they want to continue in the organization.

A.A.F.P. Annual Meeting and 31st Annual Scientific Session in San Francisco last month saw your delegates **Don Farrell** and **Felix Lafferty** represent you, together with alternates **Tom Cahill** and **Fred Reppun.** 4,904 physicians attended the Scientific Assembly, the second largest attendance in the history of the professional organization. Among them, we saw the **Jasinski's,** the **Larry Wong's,** the **Homer Izumi's,** the **Nathan Wong's,** the **Varian Sloan's, H. Q. Pang's, Don Newman.** Please let Jean know if any other members attended but are omitted from this list inadvertently. A personal assessment of the highlights of the action of the C of D includes: (1) Support of the legal fight in Michigan against the DHEW in favor of like pay for like work; (2) opposition to Federal "Cost containment" and a new dedication to promote "Cost awareness" and "Cost effectiveness" when we deal with our patients; (3) besides educating our patients in such matters of socio-medical economics, we were asked to support AAFP efforts to expand patient education in health and disease throughout the school system (see the editorial in this issue of HMJ); (4) help solve the problem of escalating medical care costs by pushing Congress to fund the education and training of more primary care physicians; (5) continued striving for Family Practice Departments in hospitals to determine privileges of new applicants, with the concurrence of approval by the other clinical departments; (6) continue opposition to National Health Insurance, federally administered and compulsory, and to join now with the "private health care industry" to come up with a plan in one year to "provide coverage for the uninsurables and for those who suffer a catastrophic illness;" (7) to continue to work for repeal of PL 93-641 but at the same time to encourage members (physicians) to get themselves onto HSA's and SAC's. The Hawaii Resolution No. 10 suggesting a probationary year if a member fails to complete required hours of CME credit, failed to pass, but the C of D passed new amendments to the By-Laws which came close to obtaining the desired effect of tightening up a loophole.

Printouts—Correcting a previous miscue, AAFP Hq will be sending each member of HAFP another printout of his or her "P," "E" or "N" hours the week of 18 December. Members, therefore, are being asked "to report all of their formal course activities for 1978 to us on their yellow computer reporting forms *before the end of November*, and individual activities in 1978 on a green reporting card."

CME—All previously submitted scientific sessions at St. Francis Hospital have been approved as "P." The Tennessee AFP will hold "Update '79 in Hawaii" at the Hilton Hawaiian Village 26 Dec to 2 Jan 79 for 15 "P" @ $200 deadline 26 Oct. California AFP invites us to its Scientific Assembly in San Diego 5-8 November. Remember our own bi-monthly dinner meeting Saturday 28 October at **Larry Wong's.**



Henry N. Yokoyama, M.D.

Life in These Parts

We received the following xeroxed clipping: "*Philadelphia Inquirer*—Friday, Aug 25, 1978 'Geography: You were expecting pineapples?' 'FLASH! The Hawaiian Islands have been admitted as the 50th of the United States, it was announced on Aug 21, 1959' . . . That may come as news to a teller at the Villanova branch of the Bryn Mawr Trust Co. A recently arrived Villanova University Law School student from Hawaii wanted to deposit a check from a Hawaiian bank to open an account Wednesday afternoon. The teller studied the cashier's check looking somewhat puzzled, until he at last figured it out, 'Oh,' he said, 'you want to change this into American dollars.' " (**Cal Sia** had given his law student son a cashier's check to open a bank account while at school . . .)

Senator Pat Saiki reported to the "Nurses Coalition for Action in Politics" on September 22nd that a Hawaii group including HMSA's **Al Yuen,** State Dept of Labor's **Sam Shimabukuro,** UH Med School assistant dean **Patricia Putnam** and herself met for two days with Carter administration officials in Washington the past week to discuss Hawaii's 1974 law, the first of its kind in the nation, wherein employers and employees share the costs and benefits of prepaid health care . . . Administration officials were impressed with the population coverage, the administration efficiency and quality control of the Hawaii program . . . Pat has a positive feeling that

federal officials were interested in including concepts of the Hawaii program into national legislation . . .

Lawrence Piette, biophysicist and executive director of the Cancer Research Center of Hawaii and physicist **Arnie Feldman** have experimented for about a year with hyperthermia to replace chemotherapy and radiation in cancer therapy. The microwave generator delivers the waves into specific areas and may be useful in inoperable tumors deep within the body . . .

The "Heart of the Year" is Ileen Wong, woman truck driver at Pearl Harbor. Ileen has been back at work since January with a pacemaker inserted in November of last year after her cardiologist, **Jef Sol** diagnosed her frequent blackouts as being due to serious cardiac arrhythmia . . .

Aina Haina pediatrician **Wayne Mckinny** is co-chairman of VIVA II Inc (Visitor Information and Volunteer Assistance). Wayne is responsible for "Refugee Sunday" which was celebrated by every church group on Oahu—Christian, Jewish and Buddhist. Collection calabashes were put out in the churches to raise funds to help incoming refugees . . .

Visiting Physician

Cardiologist-columnist **Michael Halberstam** was in town to address the annual Pac PSRO meeting and herein are a few quotable quotes (gleaned from *Star Bulletin's* Phil Mayer's column):

"The purpose of doctoring isn't to dissuade patients from their vices . . . It is to alleviate consequences . . ."

"Too many doctors dislike their patients for being ill . . ."

"We (doctors) are unloved by our patients and by the federal government . . ."

"American doctors are the least—not the most—authoritarian in the world . . . and they are expected to be part scientist, part clergyman and part miracle worker . . . We have created our own major problem, unrealistic expectations."

"With the best intentions in the world, the American Cancer Society quite possibly has caused more misery than it has prevented . . . If you save one life but scare 75 people for the rest of their lives, I doubt if you have really done any good . . . Most health education tactics have been obsolete for 20 to 40 years . . ."

"One thing is certain, five or 10 years of heavy jogging—five or more miles a day—will increase the damage arthritis does to knees . . . I think, as a heart specialist, that it does minimize the effects of heart attacks. But the jury is still out on that one . . ."

"On fitness . . . A middle-class enthusiasm . . . blue collar people aren't yet into it."

"On drugs and prescriptions: Too many Americans avoid medication because they are afraid they will become drug addicts . . . Americans aren't the world's heaviest drug users . . . Usage is a lot higher in Britain, France, West Germany and Israel . . ."

"Tums and Rolaids have probably saved Americans millions in medical costs. If most of the people who take them for upset stomachs went to doctors each time, they would have bought a lot of X-rays."

"People think malpractice judgments are paid by doctors' insurance companies . . . They aren't . . . The payment comes from doctors' souls . . . Doctors police themselves more effectively than any other group in society."

"Being ill used to be only the patient's business. Now we scold sick people because what their illness is costing is going to raise our medical plan payments."

"On Natural childbirth: Too much childbirth used to be too 'unnatural,' but there is a tendency now to give a kind of middle-class merit badge to couples who go through it and to denigrate couples who don't . . . Childbirth shouldn't be looked upon as something like 'Outward Bound.' The natural people I know—Eskimos and Indians I worked with while I was with the Public Health Service—gave up natural childbirth as soon as they discovered they could have their babies in hospitals."

Professional Moves

The medical community continues in a state of flux . . . In September, internist **James Hirasa** relocated to the new Aica Medical Building . . . so did pediatrician **Robert Ogawa** and the branch office of the Hawaii Orthopaedic Clinic (**Don Maruyama** and **Garth Morimoto**) . . . Dermatologist **Curtice Martin** joined The Fronk Clinic, Pearlridge and internist **John McDougall** opened at the Kailua Medical Arts Building, 407 Uluniu St, Kailua . . . Cardiologist **Bradley Koizumi** and gastroenterologist **Edward Kanda** opened their joint office at the King-McKinley Bldg at 1040 So King St, and orthopod **N.K. Sharma** joined the Kaiser Medical Care Programs in Wailuku and Lahaina, Maui.

In early October, internist **Elsie Blossom Wang** joined The Fronk Clinic at 839 So Beretania Street.

Miscellany

During his coronation ceremonies, John Paul I was receiving the personal blessings of world dignitaries and religious leaders. The head Rabbi came forth, handed him a weathered old envelope and spoke, "Your Holiness, please accept this humble gift of our people." The Pope had been duly instructed by his peers on this ancient ritual so he thanked the Rabbi for his kindness and promptly returned the envelope as per instructions. The Pope was curious about the origin of this strange ritual and asked one of his cardinals to investigate . . . After exhaustive perusal of ancient documents, the cardinal learned that the envelope contained the original bill for catering the Last Supper . . . (As told by **Bernard Fong** at the last Medicare Review Committee meeting . . . Bernard had heard it from a Jewish physician)

Abe, bereaved by the loss of his wife, became seriously depressed and started seeing a psychiatrist . . . The psychiatrist saw that Abe needed to improve his personal image before his outlook on life could brighten. After the first session, he told Abe to get a hair cut and get his carious teeth repaired . . . Abe did as told . . . The psychiatrist noted a definite improvement in Abe's mood and next told Abe to get a face lift . . . Abe's new face definitely improved both his appearance and psyche. The psychiatrist then told Abe to get himself a brand new red Cadillac and do the town . . . Abe did just that and while in a singles' bar, met a voluptuous blonde who seemed attracted to him. After a few drinks, she readily agreed to go for a midnight ride into the country . . . When they got to his car and he started to open the door, a bolt of lightning from Heaven struck him tote . . . Upon his arrival at the Pearly Gates, Abe complained, "God, why did you have to do this to me just as happiness was within my reach?" God spake: "Sorry, Abe, I just didn't recognize you!" (Another **Bernard Fong** joke)

Hors de Combat

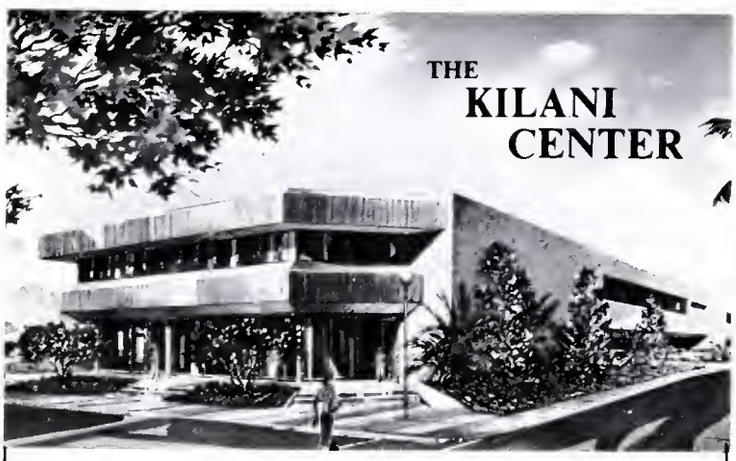
In the wake of **John Withers'** blistering criticism of inaction by Gov. Ariyoshi, a Thomas Yagi, Division Director, Maui County Division, ILWU Local 142 retorted in *Maui News'* Sept 20 "Perspective" as follows: "The misleading information being articulated in behalf of a gubernatorial candidate by a local doctor who is trying his best to convince the voters of Maui County with his professional status and urging the voters to elect his candidate for governor . . . etc. etc. . . . The ignorance of the former chief of staff of the hospital should not be laid on the governor's front door . . ." Yagi pointed out the fallacy of returning MMH to the county: "A grand total of $18,630,294 in general fund appropriations is the cost to the State for the operation of the Neighbor Island hospitals. After taking into consideration all hospital receipts which are in special funds for 1977-1979, it should be clear to anyone that the Neighbor Islands with only 20 percent of the total state population, are being supported by tax revenues generated in Honolulu with its 80% of the state population. If the hospitals are returned to the counties, each of the counties must look for additional revenues, which means higher real property taxes."

"Dr. **Cyrus Loo** is nothing if not a medical jack-of-all-trades. His business cards advise that he's a physician & surgeon, a certified skin specialist, a certified VD specialist, does acupuncture, surgical removal of facial scars & wrinkles, a certified handwriting analyst and is into mind awareness therapy . . . Besides all that, Loo is also an awesome ping-pong player as he demonstrated Sunday at the home of Dr. **Linus Pauling Jr.**" (From Daacon Jul. 11)

A $15-million, 14-year research project sponsored by the AMA Committee for Research on Tobacco and Health and funded by the nation's top tobacco companies strengthened scientific arguments that cigarette smoking is to blame for a plethora of health woes . . . "Cigarette smoking plays an important role in the development of chronic, obstructive pulmonary diseases and constitutes a grave danger to individuals with pre-existing diseases of the coronary arteries." The committee found cancer causing agents in nicotine. Researchers found possible links between cigarette smoking and a variety of other problems—most notably stroke and heart disease . . . that smoking increases the risk of blood clots that cause fatal strokes or heart attacks . . . One study found nicotine can irritate the gastrointestinal tract causing problems ranging from indigestion to peptic ulcers . . .

Local plastic surgeon **Bob Flowers** made a short term $35,000 loan to his brother Rep. Walter Flowers-D Ala. running for Senate. Walter discovered the loan to be apparently illegal. A spokesman for the Federal Election Commission pointed out that loans from family members are considered the same as campaign contributions and federal law places a $1,000 limit on such gifts or loans . . . Bob was reimbursed forthwith . . .

The State's Medicaid Fraud Control Unit has launched 11 investigations since opening in July. State Deputy Attorney General Rick Eichor, in charge of the unit, reported "It is difficult to give any estimate on the amount of it, for so long, nobody has taken the time to look at tax-funded programs like Medicaid." The unit is following up on complaints from the DSSH, the HMSA (which pays the DSSH's bills) and from the public.



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Miscellany

A fellow new in town was looking for some action and entered a likely-looking bar . . . He noticed an attractive blonde sitting alone so he moseyed over and offered to buy her a drink . . . The bartender whispered to him, "Don't waste your money on her . . . She's a lesbian." "Thanks for the tip," he told the bartender and turning to the gal, he asked, "What part of Lesbia are you from?" (As told by our golfing dentist, **Ken Ozaki**)

Sportsmen

Golfers: The annual HMA Golf Tournament was held on Wednesday Oct 4 at Mid Pac CC with 58 playing in the Doctor's Flight and 39 in the Guest Flight. The Golf Committee chaired by **H. Yokoyama** and assisted by **Bill Dang, Jim Navin, Tom Kobara** and Dorsey representative **Don Lau** had worked furiously to change the format so that the prizes would be distributed to all participants if possible, rather than the traditional few golfing elite like **Bill Dang, Alvin Parez, Charley Cachero** and **Al Chun Hoon** . . . The purpose was to eliminate the incentive for juicing handicaps before a tournament and making it a fun and frolic tournament . . . The end result was a day of relaxed golf and outrageously low net scores because the pressure to win was non-existent . . . In the doctor's flight, 4 tied with net 66's. By virtue of being the lowest handicapper of the 4, **Neal Winn** won low net, the president's trophy (donated by **Marion Hanlon**), the Miyamoto Perpetual Trophy and the next year's HMA Golf chairmanship. Overall low gross honors went to **Don Maruyama** whose name will be engraved on the John Felix Memorial Trophy . . . The other low net 66's were **H. Yokoyama** ("The Juicer"), **Tom Sakoda** and **Sakae Uehara** . . . At net 67 was **Masaru Koike.** At net 67 were **Don Maruyama, Wyman Tong** . . . At net 69 were **Tommy Chang,** and the traditional ringers **Al Parez** and **Bill Dang, Jim Navin,** and **Francis Au.** Our lone woman entrant, **Julie Cherry,** shot a net 70. **Al Chun Hoon, Garth Morimoto** and **Manual Abundo** shot net 71. At net 72 were **Allan Izumi, Quint Uy, Glenn Kokame, Catalino Cachero, Henry Fong** and **Clifford Chang.** At net 73 were **Herminio Mercado, Ernesto Orinion, Ed Emura, Bob Kim.** At net 74 were **Ed Izawa, Coolidge Wakai, Thomas Minn, Paul Sunahara, Herbert Takaki, Allan Young** and our visiting AMA president **Tom Nesbitt** . . . Grouped at net 75 were **Hideo Oshiro, L. Kiehn, Buster Richardson, Tosh Kawasugi,** and **Henry Manayan.** The prizes ran out at net 78's and eight participants went home empty-handed . . . We felt badly because it was our intent that everyone should win at least a $5 gift certificate, in addition to the 3 golf balls they received at the outset . . .

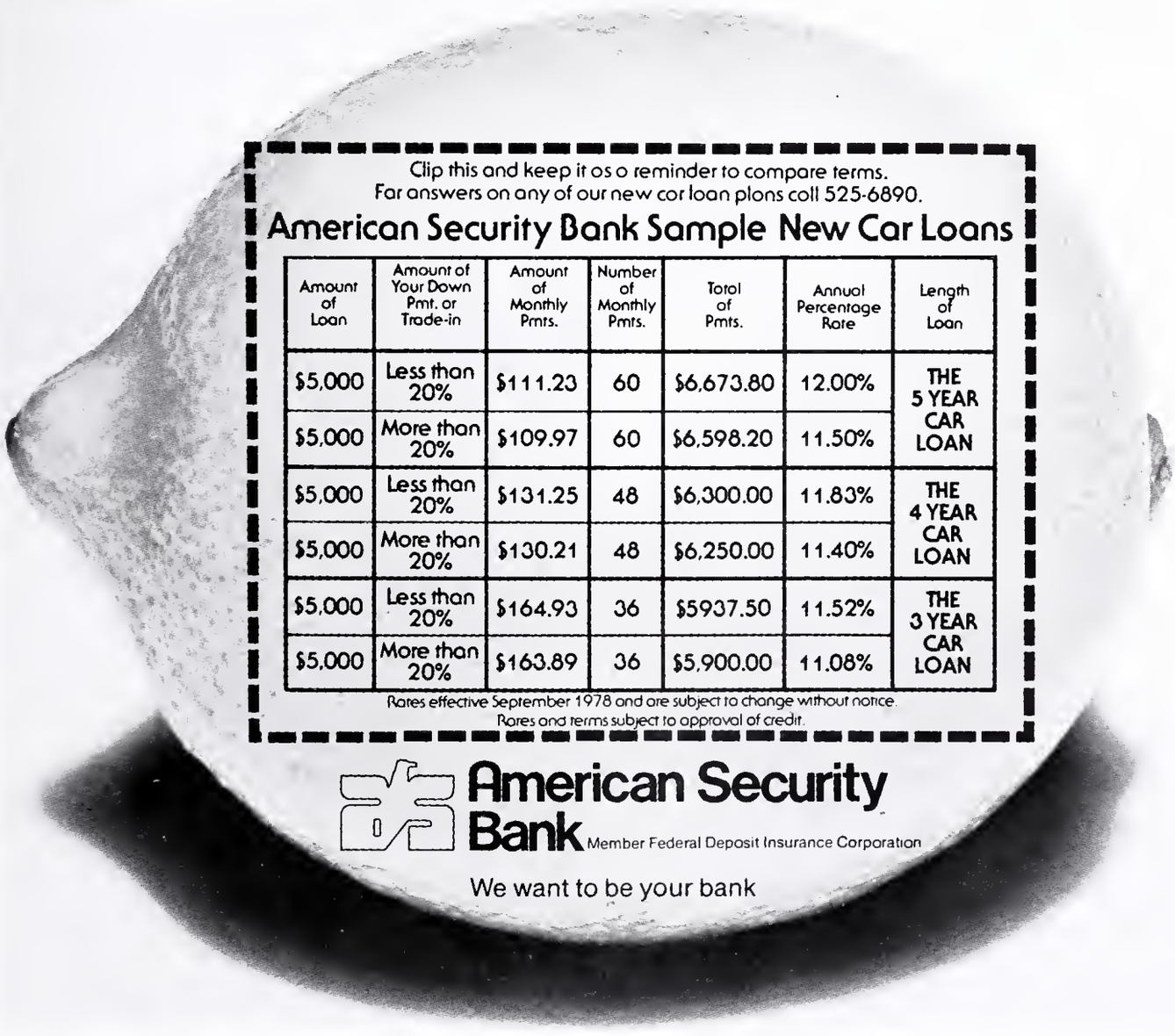
We had 39 entrants in the Guest flight, including non-HMA members, medical representatives, and druggists . . . And prizes to 27 places . . . Low gross was won by **Dave Dubois** and the George Mills trophy was won by **Bill Lawrence.**

As the outgoing golf committee chairman, we wish to thank the committee members, esp **Bill Dang** who did most of the work, from arranging for the Sportsman's Nite, the golf certificates, the scheduling, the soliciting of donations and getting the scores down . . . And our special thanks to **Tom Kobara** who arranged with his friend, **Tom Fukunaga** of Servco Pacific to have a Hole-In-One prize (A Toyota Celica adorned with a lovely girl) . . . Servco's Tom also donated two clock radios, two electric massagers, an electric shaver and a hair dryer. Tom Kobara himself donated 10 "Bridge Everyone" kits, and **Paul Tamura** of Path Associates donated $100. Other donors included AmFac (silverware), Pali Long's **Gene Machida** (clock radio), Physician's Exchange's **Adele Koch** (3 two-month beeper services), **Wally Kunimitsu** (Sanyo Slow Cooker), **Gordy Somekawa** (Norelco coffee maker), **Roy Tanabe** (West Bend Electric skillet) and **John Howard** (Air pot and shrimp fryer). **Richard Yoshino** also deserves our thanks for his donations and efforts . . .

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$5,000	More than 20%	$130.21	48	$6,250.00	11.40%	
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$5,000	More than 20%	$163.89	36	$5,900.00	11.08%	

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The Golfer . . .

The golfer is of a special breed . . . He is a man of principle and is an obsessive compulsive by nature . . . He is usually honest, straightforward and frowns on cheating . . . The golfer is guided by some special religious or superstitious fervor and a set of commandments called "Golf Rules" (which are obscured by being changed yearly) . . . He vents his frustrations by yelling incantations such as "Goddamit!" or "Ah Shit!" or by breaking or throwing his favorite club . . . If he does neither, then he tries to smash an innocent white ball into smithereens, and only succeeds in tearing up the turf . . . When his game goes sour, he is not to be blamed . . . It is the wind, the weather, the texture of the grass (whether cut short or long), the yard work he had to do yesterday, the shadow cast by a fellow golfer, the sand or cleat marks on the green, etc, etc . . . No, it would be heresy to blame himself . . . For his skill, form, and timing is perfection itself and understood only by himself . . . How do we know all this? Simply because we thought we were golfers ourselves, until a mysterious golfers' malady known as the "putting yips" afflicted us nearly two years ago . . . The putting yips is a near incurable malady which can afflict both amateur and pro and reduces even the golfing greats like Sam Snead and Arnold Palmer to blubbering idiots . . . One begins to approach every putt timorously, praying silently but fervently that you won't yip this critical putt . . . But it always happens when the pressure builds . . . We can never erase the memory of that par 3 water hole at Kauai Surf during a team best ball match back in April . . . Our partner had driven out of bounds to the left and we played it cool with two dribbles to within 10 feet of the cup . . . We raised our eyes toward Heaven, mumbled a Sutra, took a deep breath and stroked our putt so smoothly that the ball moved only 2 feet. On the next putt, there was a sudden reflex snap of our right wrist so that the ball was struck twice in a single stroke and bolted 15 feet past the cup. Our third putt skimmed past another 5 feet in the direction from whence we started . . . We closed our eyes and tried to still our pounding heart. We loosened our vice-like grip on the putter and stabbed our fourth putt which came to a stop 2 feet short of the cup. Some kind soul whispered, "That's a gimmee." The look of utter frustration and agony on our partner's face will forever haunt our dreams . . . Then the word spread fast . . . Wherever we went, in the hospital corridor, the parking lot, the stairway or the elevator, solicitous golfing friends would take us aside and offer a thousand and one remedies—from overlapping grips, to cross-handed grips, to gripping firmly, to gripping lightly, to keeping the weight on the right foot or the left foot, to crouching or to standing upright, to watching the ball with the right eye or to watching the ball with the left eye, etc, etc . . . We certainly appreciated their honest concern but it only added to our confusion and consternation . . . And to top it all, no one wanted to be our partner or let alone play with us . . . We were ready to see a psychiatrist or go to confession if it would help . . . Then haply, **Mike Okihiro** (good ole buddy) came to our rescue and showed us how to relax and sight down the club head "as in a tunnel" and our putts started to go straighter and smoother. And for some mysterious reason, our spouse gave us a "Dynabee" (a plastic sphere containing a gyro) which was supposed to strengthen the wrists and forearms and which took us two weeks before we could actually start the gyro spinning. Suddenly we had lost our yips and golf was no longer a nightmare . . . When we won the Medical Arts Tournament with a ridiculous net 63 at Leilehua, we could hear the words "ringer" and "juicer" describing our character and they sounded like sweet music. Again when we tied with 3 others in the HMA tournament with a net 66, we gloried in the realization that we could finally play normally again and that we were not really ready for the golfer's graveyard . . . The saying should go, "Ole golfers never die . . . They simply lose their balls . . . or get putting yips."

Miscellany

Three drunks in a bar were arguing about who would have created woman if the creator had been a mortal. The first drunk said, "Could have been an artist since women have such aesthetic qualities." The second drunk remarked, "I vote for an engineer because a woman is built so structurally perfect." The third drunk ended the argument, "It has to be someone on the City Planning Commission . . . Who else would put the recreational area next to the sewage disposal . . ." (A **Ken Ozaki** joke)

HMA 122nd Annual Meeting Lecture Notes

Hi-lites of **Leon Speroff's** lecture, "Estrogen Therapy: Pros & Cons":

Obese women have more endogenous estrogen . . . The potency of hormones depend on blood concentration, affinity of H and R, receptor quantity, and affinity of HR and DNA . . . Estrogen receptor is turned off by a. progesterone b. chromatin and c. testosterone (b and c turn off estrogen receptors of the brain) . . .

Schedule for estrogen therapy: Ist week: Premarin 0.625mg daily; 2nd week: Premarin 0.625mg daily; 3rd week: Premarin 0.625mg plus Provera 10mg daily; 4th week: No hormone Rx . . . (Provera apparently prevents endometrial CA, but its effect on breast CA is unknown . . .) If withdrawal bleeding occurs on the 4th week, reduce estrogen dose . . . Even the smallest dose contraceptive pills have excess estrogen; hence greater risk.

For hyperplasia, therapy includes hysterectomy, Provera + Premarin regimen, or high dose progesterone . . . Breast CA: If estrogen assay (receptor assay) is sensitive, do not use estrogen; if not sensitive, give estrogen . . . Evidence from 3 year estrogen study shows increased bone density even in women in their 70's . . . Replacement therapy should be offered to all postmenopausal patients . . . Vaginal epithelium is so sensitive to estrogen that we cannot use vaginal cytology to adjust estrogen dosage . . .

Hi-lites of **Alan Nies'** lecture, "Beta Adrenergic Blockers":

The adrenergic neuron stimulates both alpha receptors and beta receptors . . . Beta receptors include cardiac receptors B1, bronchial receptors B2, vasodilator receptors B_2, and metabolic receptors . . . Experimentally, propranolol is a competitive blocker of Isuprel . . .

Exercise effect on heart rate related to propranolol dose a. Maximal effect of propranolol: blocks to 100 to 110/min b. 50 to 100 mg of propranolol gives maximal effect on exercise tachycardia; c. Even smaller doses have effect on exercise tachycardia . . .

Other effects of propranolol: a. Membrane stabilizing agent, ie blocks ion flux thru cardiac muscle and membrane, and prevents depolarization . . . Hence a more potent local anesthetic than Lidocaine . . . b. Propranolol metabolites: 70% of propranolol taken orally goes thru liver . . . therefore IV dose more potent c. Alters 0_2-Hb dissociation viz increases 0_2 delivery to tissues d. Alters platelet aggregation.

Indications for propranolol: a. Angina, b. Arrhythmia, c. Hypertension . . .

Role in Angina: propranolol slows heart rate, decreases contractility and lowers ventricular wall tension (thus lowers 0_2 demand) . . . Start with small doses and do not rely on blood levels . . . Propranolol may cause fatigue as a side effect . . . It decreases infarct size in MI with less CPK release if given a dose of 160mg/d (esp with an IV bolus) within 4 hours after MI onset . . .

Role in Arrhythmias: 1. Atrial: Very useful in converting to NSR esp with paroxysmal tachycardia . . . In atrial fibrillation, blocks A-V node . . . 2. Ventricular: Some evidence that ventricular arrhythmias are caused by catecholamine . . . Thus propranolol should work on catecholamine-induced arrhythmias . . . Sporadic ventricular arrhythmias: 70% effective with propranolol . . . Better tolerated than quinidine, Norpace or procaine amide . . . Dosage: If dose is stopped at 160mg/d, then only ½ of the cases respond; At 480mg/d then 60 to 70% respond . . . Controls PVC frequency esp on post MI patients . . . A 2-year study with Aterenol shows less sudden deaths and reinfarction (either by 0_2 sparing effect or the anti-arrhythmic effect).

AMA Challenges in the Courts

One of the professions's major concerns today is government's mounting pressure for increasing regulation of medicine. In response to these challenges, the AMA has taken a new position of advocacy for physicians and the public which has resulted in the AMA's very first lawsuits against the government.

In March 1975, the AMA took HEW to court over its Utilization Review Regulations which required review of all Medicare and Medicaid hospitalizations within 24 hours. The AMA contended the regulations constituted unlawful interference with the rights of physicians and patients. The AMA won its case and HEW withdrew the regulations.

The AMA also initiated legal action against HEW's Maximum Allowable Cost Rule, charging that the rule, which would govern the prescription of drugs for Medicare and Medicaid patients, intrudes on clinical decisions made by physicians. The case is now pending.

The AMA has also joined with co-plaintiffs, the state of North Carolina, the state of Nebraska and the North Carolina Medical Society, in a suit against the Health Planning Act of 1974 which gives the Secretary of HEW sweeping powers over nearly every aspect of health care.

These are just some of the many actions the AMA has taken to protect your rights and interests and the rights and interests of your patients. With your support, it can be even more effective.



Join us.
We can do much more together.

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Role in Hypertension: Average dose 160mg/d . . . Most commonly used in combination with diuretics or vasodilators . . . Dosage used in Europe: 2000mg/d (with 250 to 500mg tabs) . . . Dr. Pritchard in England uses 4000 to 6000mg/d . . . As a solo drug, most high renin patients respond at 160mg/d; with low renin patients, higher doses required . . .

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Caution: A. Withdrawal phenomena: taper off drug at rate of ½ dose every 2 days . . . Abrupt withdrawal results in rebound phenomenon . . . Metroprolol may be used in place of propranolol when bronchospasm occurs . . . Propranolol also used in migraine, postmenopausal flushes . . .

Quotable Quotes

"There is only one way to treat a cold and that is with contempt . . ." (Osler)

"We see so far because we stand on the shoulders of giants . . ." (Isaac Newton)

Bulletin

Straub pathologist **Jim Navin,** erstwhile member of the HMA Golf Committee magnanimously donated $1.00 to the tournament fund when he couldn't get change for a $20 bill. Acknowledgments, however, were premature because when he found change, he withdrew his dollar donation . . .

Letter to the Editor

Sept 20, 1978

Dear Sir: The *News & Notes* report on the Maui Memorial Hospital controversy as reported in your August, 1978, issue made interesting reading but is certainly one-sided reporting. Dr. Wither's interpretation of the meeting atmosphere and proceedings does not reflect the attitude and interpretation of a significant number of the doctors, and a minority statement by Dr. Bertram Weeks was completely ignored.

May I also remind you that the one who throws "s--t" ends up smelling just as bad as the one who catches it.

Sincerely,
Marion L. Hanlon, M.D.

(Dear Marion: We like that . . . No mincing of words . . . Tell it like it really is . . . Sorry we missed Bertram Weeks' remarks . . . We were beginning to wonder about you Maui guys . . . Ed.)

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Letters to the Editor

Continued from page 291

physicians in Hawaii Nei who made my years of practice such a pleasant experience. The day that I decided to stay in Hawaii was a lucky day for me.

My working days in private practice are coming to a close, but next June when I finish I shall have many pleasant memories. Among these memories will be the honor of having been selected as a Physician of the Year by my colleagues. To all those who made this possible a large-sized mahalo. To all of my colleagues, past and present, who for 33½ years have made the practice of medicine in this community a memorable and happy experience, another mahalo! The doctors of Hawaii are indeed the greatest! With much aloha,

MORTON E. BERK, M.D.

Our "Angels"

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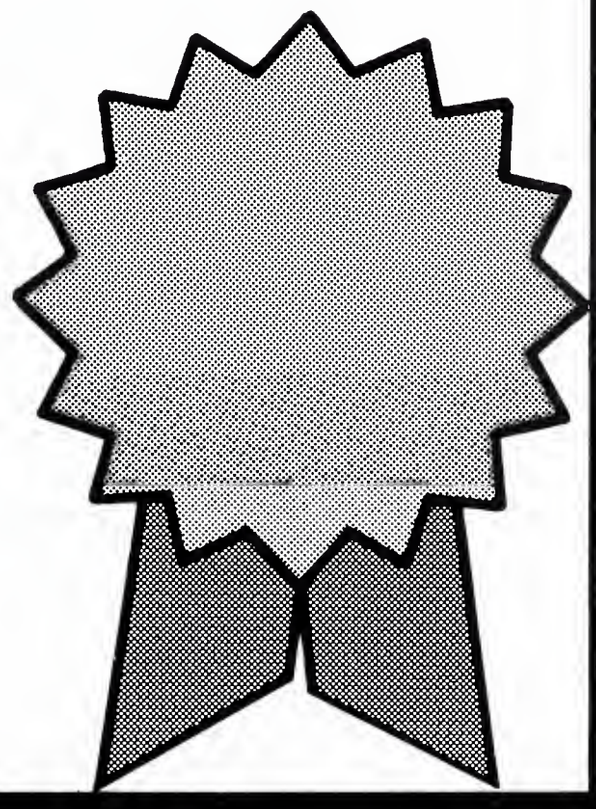
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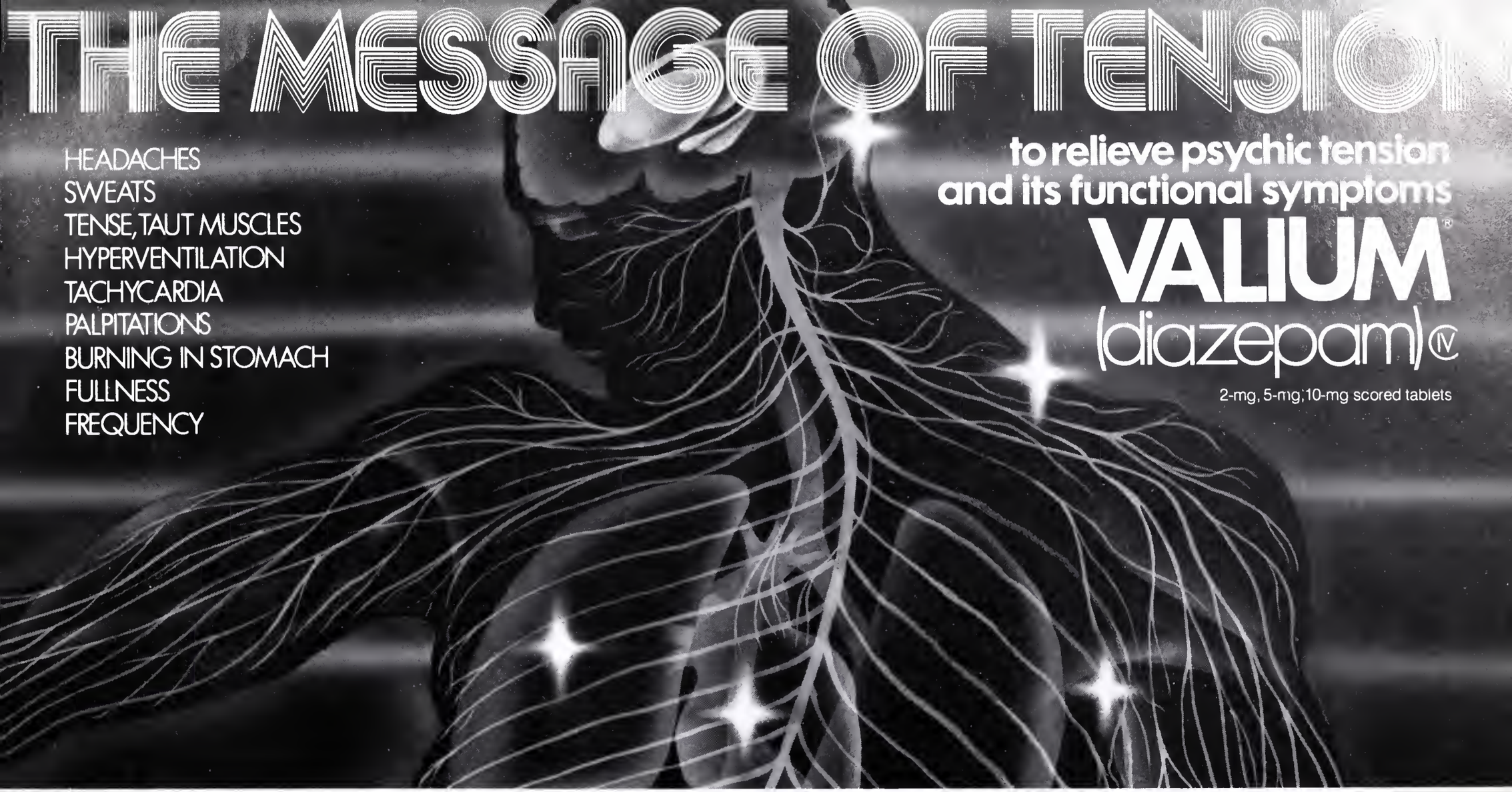
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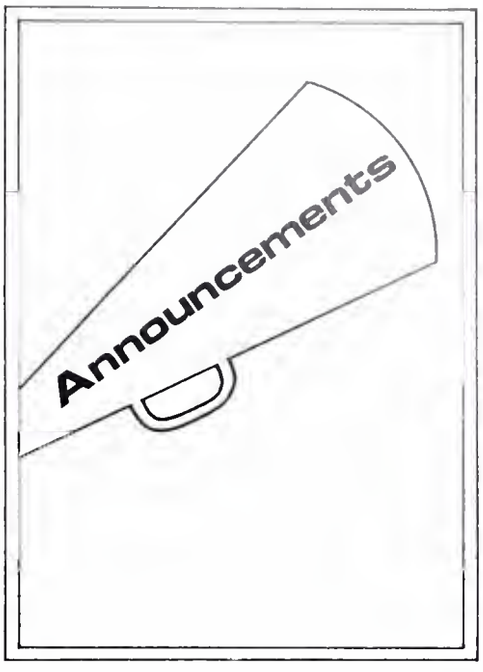
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Hawaii Society of Internal Medicine

BIG NEWS!! In our quarterly meeting, we're having the good fortune of having Senator Dan Inouye as our featured speaker to discuss several medical bills pending. The Senator has always been a knowledgeable and fair participant and we are indeed fortunate to have a man of his caliber talking to us. The date depends on when he can come.

I just received my malpractice insurance renewal and was delighted to find out they had cut my premium by $316.00 a quarter or $1,2464.00 a year—thanks to the efforts of the ASIM. ASIM went to the insurance council and convinced them that needle liver biopsies and renal biopsies did not expose the doctor to enough risks that he should be put in class 2. It's great to be put back in class 1 again and saving all that money. This pays for my dues 10 times over.

ASIM is getting closer to where the action is. They are moving to Washington, D.C. They are really following the lead of Roberta Fenlon, M.D., who went there in 1966 and spent a year officially representing ASIM and convincing HEW that it would be wise to cut their 3-page form for all Medicare patients down to a 1-page form that doctors could live with. Bill Felts kept this line of communication open and as a result, ASIM has been able to guide the congressmen into realistic pathways in dealing with many medical problems. We'll all miss the San Francisco home base, but things are moving hot and fast and it's mandatory that we be close to the horse's mouth.

RAY DEHAY, M.D.
Secretary

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Stead, W.W. and Bates, J., in Harrison's Principles of Medicine,
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Reference: Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N.Y. 1969

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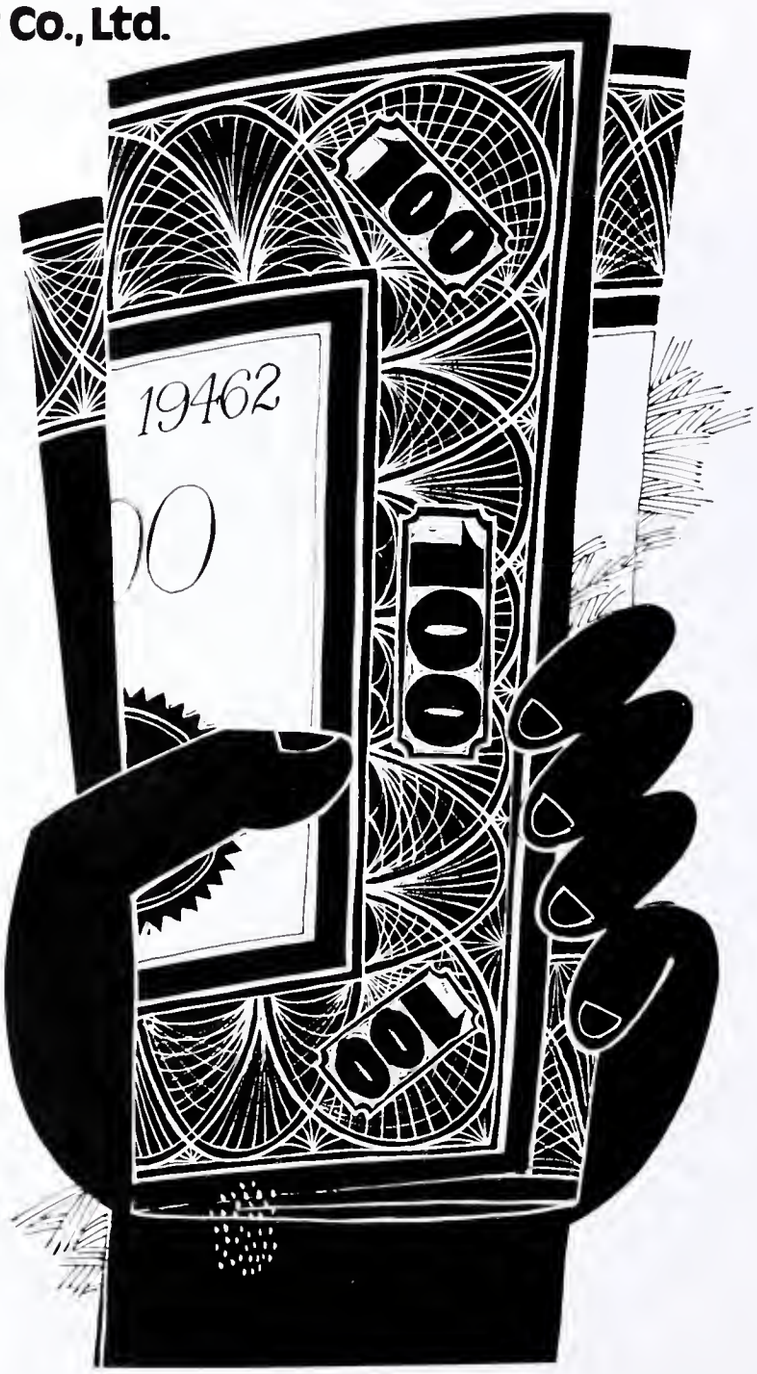
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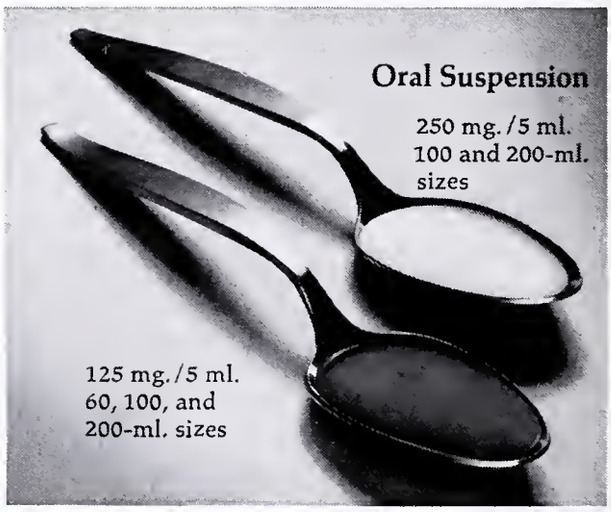
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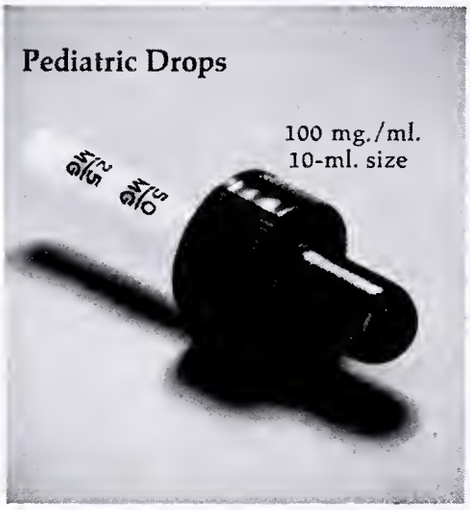
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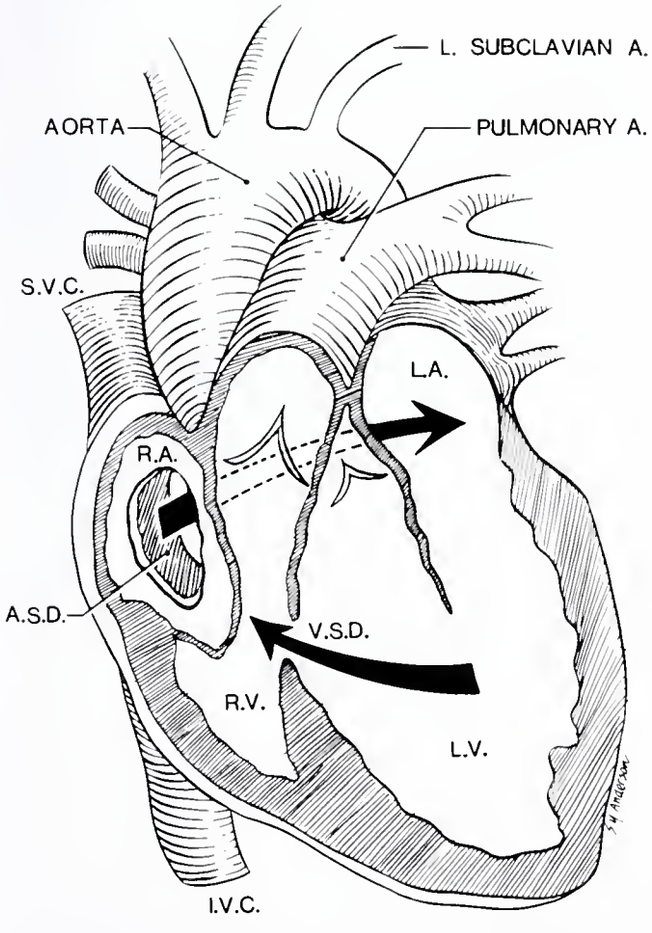
Successful Total Correction of Tricuspid Atresia

GEORGE K. T. CHUNG, M.D., J. JUDSON McNAMARA, M.D., ERNEST K. H. LEE, M.D., SCOTT BRAINARD, M.D. *and* ARTHUR SPRAGUE, M.D., *Honolulu*

Tricuspid atresia is characterized by cyanosis and heart failure in infancy and is accompanied by a high mortality.[1,6] Anatomically, besides the atresia, there is usually:

(1) a large interatrial septal defect,
(2) a dilated hypertrophied left ventricle,
(3) an interventricular septal defect (VSD) and hypoplastic right ventricle, and
(4) normal relations of the great vessels.[1]

FIG. 1.—*Anatomy of tricuspid atresia. Arrows indicate direction of shunts.*



Palliation by improving blood flow to the lungs with either a superior vena cava-to-right pulmonary artery shunt (Glenn Procedure) and/or a subclavian-to-pulmonary artery shunt (Blalock Procedure) diminishes the cyanosis and allows the patient to survive into the second and third decade when death intervenes, usually from left ventricular failure and hypoxemia, unless further corrective surgery is undertaken.[1]

Interposition of a valved conduit graft between the right atrium and main pulmonary artery and closure of the septal defects is now possible and corrects all the major pathophysiological aspects of the anamoly, ie, inadequate oxygenation and left ventricular overload.[1,2,3,4,6]

In May, 1977, the first total correction of this anamoly was performed in Honolulu and is the subject of this report.

History and Examination

A 23-year-old college student complained of increasing cyanosis and dyspnea on exertion. Tricuspid atresia had been diagnosed in infancy. At 3 months of age he underwent a left subclavian artery-to-pulmonary artery shunt and at age 14 years, a superior vena cava-to-right pulmonary artery shunt. Recently he had been hospitalized repeatedly for congestive failure.

He appeared cyanotic with clubbing of the digits. There was cardiac enlargement and a systolic murmur. The liver was enlarged. He was dyspneic at rest.

Chest x-ray revealed cardiomegaly and increased pulmonary vasculature. Classical left axis deviation and left ventricular hypertrophy were present in EKG. The hematocrit was 62% and arterial oxygen saturation 83%. Cardia catheterization showed patent Glenn and Blalock shunts.

Operation

Via a median sternotomy, exposure and control of the shunts were accomplished first. The

Accepted for publication July, 1978.
Art work by Susy Anderson.

left-sided Blalock shunt was approached through the mediastinal pleura, with the palpable thrill used as an aid in locating the anastomosis. The area of the superior caval-pulmonary artery shunt was densely scarred. This tedious dissection was facilitated by using the innominate vein as a landmark leading to the vena cava.

Cannulation sites for cardiopulmonary bypass were the ascending aorta, the left common femoral vein, and the superior vena cava just cephalad to the Glenn anastomosis.

Before starting bypass, the Blalock shunt was doubly ligated.

On cardiopulmonary bypass, a vertical incision was made first in the proximal pulmonary artery extending into the hypoplastic right ventricle. The small (5-10mm) VSD was closed directly with interrupted sutures.

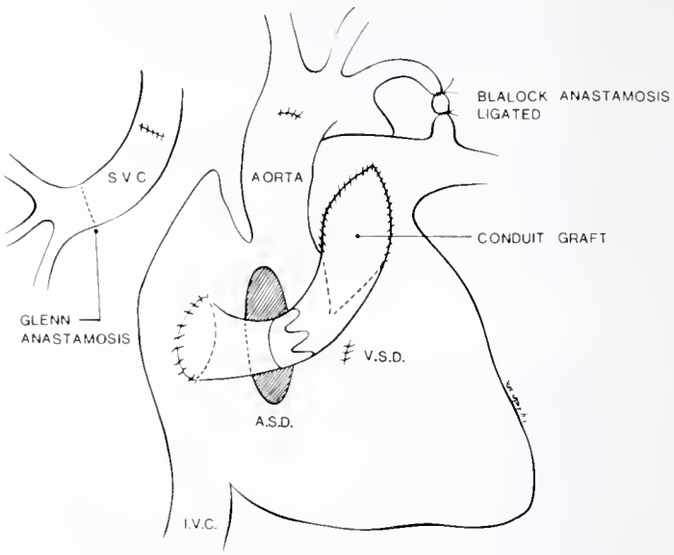
Next, the right atrium was opened longitudinally and a 5 cm diameter atrial septal defect (ASD) noted. Exposure was impossible because of copious return of blood into the atria. Cross-clamping of the aorta to eliminate coronary sinus return did not help. The Blalock shunt was re-examined and found to be closed. No evidence of ductus arterious was found to explain the flooding, which was ascribed to bronchial collateral circulation, built up over years of hypoxic stimulation. Therefore, the patient was cooled to 20°C and the flow rate from the heart-lung machine decreased to one liter/minute. This controlled the bronchial return, regained exposure, and the ASD was closed with a dacron patch.

Full flow was re-established and the conduit graft containing a porcine valve prosthesis was then sewn from the right atriotomy to the right ventriculopulmonary arteriotomy to complete the correction. Cardiopulmonary bypass was easily terminated, and the superior caval venotomy closed with a running suture.

Post-operatively the patient's course was complicated by tamponade, mild to moderate heart failure, and transient respiratory insufficiency. These responded to appropriate supportive measures and the patient was discharged 18 days after surgery on digoxin, diuretic, and coumadin.

He did well and, 9 months later, was pink and much improved in exercise tolerance. His left ventricle remained enlarged, however, and he was still taking digoxin and diuretics at the time of this report.

FIG. 2.—*Completed correction of anamoly with conduit graft closure of ASD & VSD.*



Discussion

The fact that the right ventricle is not necessary for normal circulation makes the conduit graft procedure (so-called orthoterminal connection) possible.[1,2,3] Six other cases of tricuspid atresia in Honolulu were reviewed and, in all but one, the anatomy was, theoretically, suitable for correction.[5,6]

Certain technical points during operation bear emphasis:

(1) The take-down of the Glenn Procedure may be difficult because of scarring, but use of the innominate vein as a landmark helped to identify the vena cava and the proper dissection planes.

(2) The bronchial artery return may flood the operative field, obscuring everything, as well as jeopardizing adequate cardiopulmonary bypass. The flooding can be handled by moderate hypothermia to 20-22°C and decreased flow rates on bypass (1-1.5 liters/minute).

Summary

A successful case of total correction of tricuspid atresia is reported and discussed.

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Restoration of Male Fertility Five Years After Total Hypophysectomy

WERNER G. SCHROFFNER, M.D., *Honolulu*

• *The development of purified gonadotropin preparations for the treatment of pituitary hypogonadism has added recent knowledge about the physiologic role of gonadotropins.*[1-7] *Mancini* et al[4,5] *used serial testicular biopsies as parameters of gonadal response to therapy. According to their studies, the length of time elapsed between hypophysectomy and the initiation of gonadotropin treatment did not affect the end results adversely.*

A significant rise of sperm counts has been reported in few treated hypophysectomized men.[1,3,6,7] The opportunity to see gonadotropin therapy in such patients through to its ultimate effectiveness—fathering a child—has rarely been reported.[6,7] The following study of a man who achieved fertility 5 years after sella evacuation and irradiation provides further understanding about the role of gonadotropins in initiating and maintaining spermatogenesis.

Case Report

A 24-year-old Japanese man was referred for the management of infertility in January, 1975. A transfrontal removal of an intrasellar tumor, diagnosed as craniopharyngioma, had been performed in July, 1970.

His physical and sexual development prior to this surgery had been normal. Preoperative findings were sella enlargement, bitemporal hemianopsia, morning plasma cortisol 6 μg/dl, urinary 17-hydroxycorticoids 6 mg/24 hrs (normal 8-25 mg/24 hrs) and serum thyroxine 3.8 μg/dl (normal 3.2-6.5 μg/dl). Complete sella evacuation was followed by 7000 rads of cobalt therapy to the sella. A metyrapone test one month postoperatively had shown no rise from a low baseline urinary 17-hydroxycorticoid level of 5 mg/24 hrs. The patient was treated postoperatively with hydrocortisone and desiccated thyroid.

Department of Medicine, John A. Burns University School of Medicine, Honolulu, Hawaii 96813.

Presented in part at the ACP Hawaii Regional Meeting, March 1977.
Accepted for publication June, 1978.

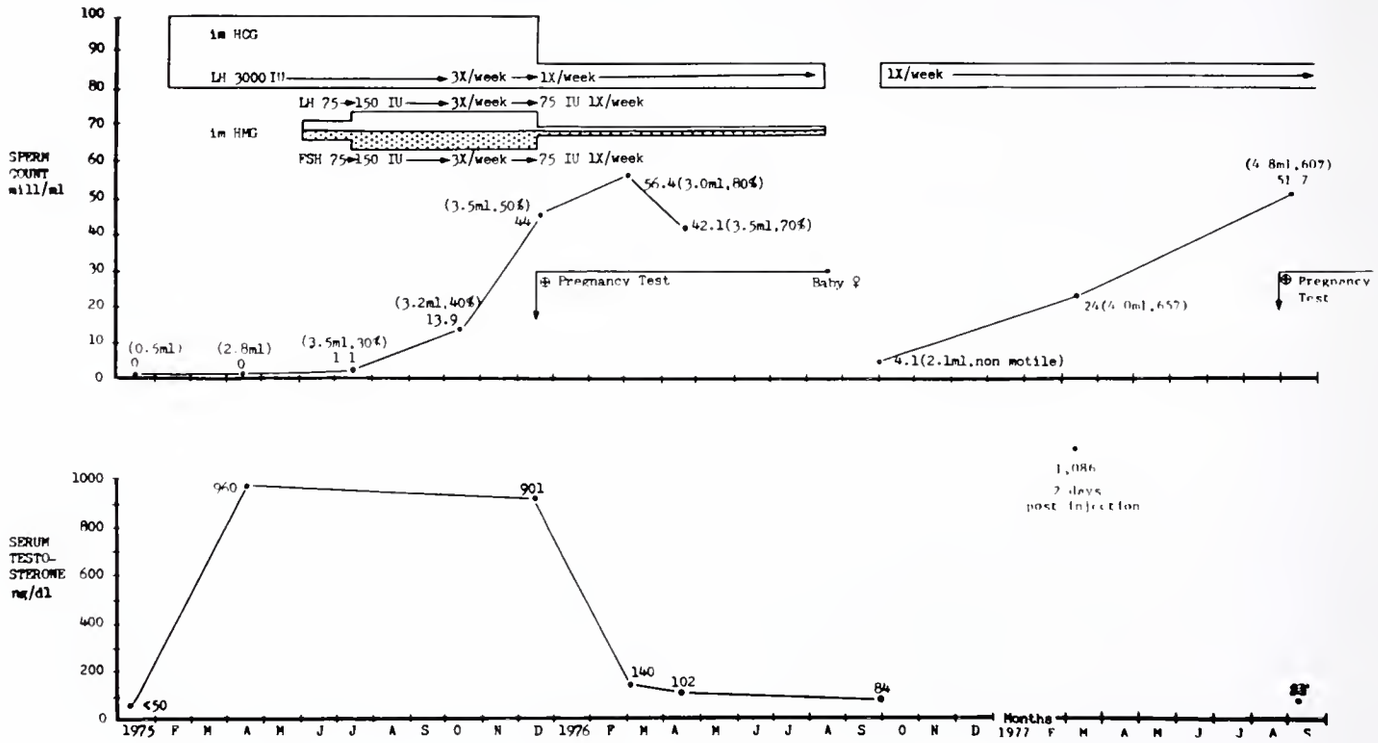
When seen again one year later the patient complained of tiredness, impotence, failure to ejaculate, and decrease in sexual hair. His serum testosterone was 25 ng/dl (normal 400-1000 ng/dl). He took oral fluoxymesterone, prescribed 5-10 mg daily, irregularly until December, 1974, when a sperm count was zero. Bilateral testicular biopsy showed decreased tubular diameters, peritubular hyalinization, basement membrane thickening of the seminiferous tubules, and few Leydig cells and spermatogonia. Occasional Sertoli cells were seen.

Physical examination in January, 1975, showed a normally developed man. Blood pressure was 104/72 mmHg and heart rate was 44 beats/min and regular. Bitemporal hemianopsia was noted. Facial hair was moderate. Axillary hair was normal. Testes measured 3 cm in length and were softer than normal. The prostate was small. The skin appeared dry, and Achilles reflexes were sluggish.

Laboratory tests showed a normal complete blood count and normal chemistries. Serum testosterone and serum luteinizing hormone (LH) were unmeasurable, and serum follicle stimulating hormone (FSH) was 8 mIU/ml (normal 4-25 mIU/ml). Azoospermia was evident on two ejaculates. The patient was treated with daily oral maintenance doses of prednisone, 5 mg in the morning, 2.5 mg in the evening, and thyroxine 0.2 mg, and was started on gonadotropin injections. He was clinically euthyroid when he was seen 4 weeks later.

Human chorionic gonadotropin A.P.L. (Ayerst) (HCG) was continued intramuscularly in a dosage of 3000 IU 3 times a week for a total of 9 weeks (Fig. 1). Libido, muscle strength, and the need for shaving increased gradually, and facial acne started. A rise in serum testosterone level from less than 50 ng/dl to 960 ng/dl (preinjection) occurred, with a slightly increased volume of seminal fluid but persistent azoospermia. Additional human menopausal gonadotropin

FIG 1.—*Effect of HCG-HMG therapy on sperm counts and serum testosterone levels. Volume of ejaculate and percentage of motile sperm one hour after ejaculation are in parenthesis. Over 85% of the spermatozoa had a normal morphology. The designations LH and FSH refer here to LH-like and FSH-like activity, respectively.*



Pergonal (Serono) (HMG) with 75 IU each of LH-like and FSH-like activity per 2 ml ampule was given intramuscularly in a dosage of 2 ml 3 times a week. Within 6 weeks spermatozoa appeared in the ejaculate. The dose of HMG was doubled, and at 28 weeks of HMG, the sperm count was 44 million/ml. Subsequently, the patient's wife became pregnant and a normal baby girl was born. Smaller and less frequent doses of gonadotropins had been injected after conception, enough to maintain spermatogenesis until the offspring was secured. On a reduced once-a-week dosage schedule of HCG 3000 IU and HMG 150 IU, the pre-injection serum testosterone levels dropped to 140 ng/dl and then to 102 ng/dl, while the sperm counts and motility remained relatively unchanged.

Interruption of treatment for 6 weeks after the child's birth resulted in severe oligospermia, loss of sperm motility and further decrease in serum testosterone. Weekly injections of HCG 3000 IU were resumed as shown in Figure 1. Libido, potency, muscular strength, and beard growth were very good on that dosage. Occasional delays of the injection by 2-3 days were associated with complaints of declining potency. After 5 months, the sperm count had risen to 24 million/ml, and the serum testosterone was 1086 ng/dl 2 days post-injection (Fig. 1). When the patient's wife was found pregnant eleven months after the reinitiation of HCG, final testing was done. The sperm count was 51.7 million/ml which was within the range previously associated with fertility. The pre-injection serum testosterone was 85 ng/dl, and serum FSH was 1.8 mIU/ml.

Discussion

Treatment schedules to restore or maintain fertility in hypophysectomized men have not been established. Some reasons for this may be the patient's age and social circumstances making fertility undesirable, the tacit assumption by both physician and patient that fertility cannot be regained, the high price of currently available injectable gonadotropins, and the prolonged course of treatment required without the assurance of predictable success.

The testicular biopsy in this particular patient was typical of prolonged pituitary failure, although the basement membranes of the seminiferous tubules were not severely thickened. Fluoxymesterone may suppress testosterone levels (and, to a small degree, spermatogenesis) without affecting gonadotropin levels;[8] however, this drug had been stopped several weeks before testing.

The first goal of therapy was to raise the serum testosterone levels to normal with the LH effect of HCG. As this would reflect regeneration of Leydig cell function, restoration of normal intratesticular concentrations of testosterone could also be assumed. Morse *et al*[9] found intratesticular testosterone concentrations about 100 times higher than serum testosterone concentrations in normal men. The importance of intratesticular testosterone for effective tubular function has been further illustrated by a case of prepubertal Leydig cell tumor leading to spermatogenesis.[10] Finally, a relationship was found between development of germinal epithelium, reduction of

hyalinization in the same seminiferous tubule, and the presence of differentiated Leydig cells in the vicinity following gonadotropic stimulation.[5]

At a time when the testosterone level had normalized and the ejaculate volume had increased, there was still azoospermia in this patient. This would be expected, as HCG treatment in both hypophysectomized men[5] and prepuberal boys[11] matures spermatogenesis only to the pachytene stage of primary spermatocytes and not to the final spermatozoal stage.

The addition of HMG to HCG treatment—with FSH-like activity being a small fraction (1/40) of the total amount of LH-like activity—raised the sperm count to 1.1 million/ml within only 6 weeks. This indicates some maturation of spermatogenesis prior to HMG administration since, according to Heller and Clermont,[12] the time required from the spermatogonial to the final spermatozoal stage is as long as 74 days. The effect of any residual pituitary FSH secretion is probably not important, since the rising endogenous testosterone levels would suppress it during HCG administration.[13] According to Mancini *et al*,[5] LH effects alone accomplish a major portion of testicular regeneration, such as regression of hyalinization, maturation of Leydig cells, increase of spermatogonia and Sertoli cells, and appearance of primary spermatocytes, while FSH activity alone affects the Sertoli cells only. Yet, FSH activity combined with excess LH activity was required for full regeneration of Sertoli and Leydig cells and spermatogenesis in previous patients,[4,5] and led to fertility in this patient. The duration of his treatment was dependent upon his response, with the dosages arbitrarily guided by the experiences of MacLeod *et al*,[3,7] Granville,[6] and Santen and Paulsen.[14] At the reduced weekly dosage of HCG 3000 IU and HMG 150 IU, after the beginning of his wife's first pregnancy, active spermatogenesis was maintained in spite of low pre-injection serum testosterone levels. Presumably, intratesticular testosterone concentrations were still adequate to promote effective seminiferous tubular function.

The patient's failure to appear for injections after the delivery of the baby offered a unique opportunity to follow the recovery of spermatogenesis from severe oligospermia back to a level associated with fertility. MacLeod and Johnson[7] pointed out that, although in their 2 hypophysectomized patients HCG alone could not reinitiate spermatogenesis after withdrawal of all gonadotropins, it was sufficient to maintain spermatogenesis on an alternate-day dosage schedule once fertile levels had been achieved. The frequency of HCG injections in this patient was determined by his need with regard to libido and potency, which is reflected in a high serum testosterone level 2 days after HCG and a subnormal level of 85 ng/dl one week after HCG (Fig 1), ie, immediately prior to injection. Similar testosterone levels in relation to HCG administration were found during the initial 18 months of therapy. No more than weekly doses of HCG 3000 IU restored fertile sperm levels after oligospermia in this case, while higher and more frequent dosages of HCG failed to do so once azoospermia had been reached in similar cases.[7] The "point of no return" from regressing spermatogenesis without the addition of HMG to HCG therapy remains to be seen, as well as what minimum total amount of HMG might actually be needed to provide the initial momentum on the way to successful treatment of infertility in hypophysectomized men.

Conclusion

It is concluded that HCG-HMG treatment was effective in inducing male fertility even after prolonged interruption of endogenous gonadotropic stimulation following hypophysectomy. A weekly dosage of HCG 3000 IU established by the patient's subjective need can be used as maintenance therapy. Maintenance of fertile sperm counts as long as future offspring is considered would mean reproductive readiness without the long "priming" period required once oligo- or azoospermia develops.

Summary

Fertility was desired by a 24-year-old man with hypopituitarism 5 years after sella evacuation and irradiation for craniopharyngioma. Laboratory tests showed azoospermia, atrophy and basement membrane thickening of the seminiferous tubules, and only a few Leydig cells. Administration of human chorionic gonadotropin (HCG) 3000 IU intramuscularly 3 times a week for 2 months raised serum testosterone levels from less than 50 ng/dl to 960 ng/dl without affecting the sperm counts. Additional human menopausal gonadotropin (HMG) 150-300 IU intramuscularly 3 times a week for 6 months increased the sperm counts to 44 million/ml, resulting in a pregnancy and eventual childbirth. Unchanged spermatogenesis was maintained for at least 4 months on weekly injections of HCG 3000 IU and HMG 150 IU with pre-injection serum testosterone levels being less than 150 ng/dl. Cessation of therapy resulted in oligospermia but a sperm count of 51.7 million/ml and pregnancy were achieved again on HCG IU once a week. Fertility after prolonged hypopituitarism can be restored with combined HCG-HMG and maintained with HCG alone.

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Are viruses or bacterial toxins to blame?

Pseudomembranous Enterocolitis After Ampicillin Therapy

GERALD A. HIATT, M.D., *Honolulu*

• *Antibiotic-related pseudomembranous enterocolitis (PME) is now a well-recognized entity. In the last several years, there have been numerous reported cases of PME following treatment with tetracycline, chloromycetin, lincocin, and clindamycin, with the result that further case reports are no longer new information to most physicians. More recently, ampicillin has been incriminated in several cases of PME, some ending fatally, and this complication of this widely used drug may be less well known in Hawaii. To amplify this association, we report an additional case and briefly discuss the etiologic theories.*

Case report

A 43-year-old woman was felt to have moderately severe bronchitis and was started on a 5-day course of ampicillin, 500 mg every 6 hours. Two days after finishing therapy, she experienced generalized abdominal cramping, diarrhea, and fever. The next day she was lethargic and her temperature was 102.6°F. Abdominal and back tenderness were noted. The urinalysis was normal, and the white blood cell count was 24,900. An infectious diarrhea was suspected, and she was restarted on ampicillin at the same dose. Two days later her temperature had decreased to 98.8°, but her abdomen was still tender. The white blood cell count had decreased to 20,500. Ampicillin was continued. Two days after that visit, following 9 days of ampicillin therapy, she was admitted with a temperature of 101°F and exhibiting lethargy, dehydration, and generalized abdominal guarding.

Hospital management initially included IV fluids, pain medication, and diphenoxylate hydrochloride with atropine (Lomotil). The ampi-

The Fronk Clinic, 839 South Beretania Street, Honolulu, Hawaii 96813.

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cillin was discontinued. Proctosigmoidoscopic examination revealed a friable mucosa and a profuse, yellowish-white discharge that prevented close inspection of the mucosa. Smears showed predominantly gram-positive organisms and white blood cells. Monilia was not detected. The examination was repeated three days later, clearly revealing scattered yellow-white plaques on an erythematous mucosa. Smears were identical to those previously done.

Temperature was 100.2°F on admission, rising to 101.6° and returning to normal on the second hospital day. Admission white blood cell count was 17,700, decreasing to 9,700 on discharge. Total serum protein determinations were 5.1 and 4.4 mg% with albumin fractions of 3.4 and 2.7 mg%. These low values were felt to indicate a protein-losing enteropathy in the form of her severe colitis. Chest x-ray revealed small, bilateral pleural effusions and mild atelectasis, assumed to be the result of hypoproteinemia. Subsequent chest x-rays showed complete clearing. Blood and stool cultures were negative as were stool examinations for ova and parasites.

Acute abdominal series showed evidence of small and large bowel ileus, and barium enema examination revealed coarsening of mucosal folds in the ascending colon and cecum, and a partial loss of the haustral pattern with an irregular, feathery mucosa in the descending colon and sigmoid. The terminal ileum was normal (Figure 1).

FIG. 1.—*Barium enema showing diffuse mucosal changes, most marked in the cecum, descending and sigmoid colon.*



Colonoscopy on the seventh hospital day, when the patient's symptoms had markedly improved, revealed scattered white plaques on a mucosa that was either slightly erythematous or normal (Figure 2).

FIG. 2.—*Colonscopic view showing a white membrane on an erythematous mucosa.*



Lomotil was discontinued, and the patient gradually improved. Steroids were not used.

Comment

PME is a disorder with no single known cause. It is limited, at least initially, to the mucosa and was classically described after heavy metal poisoning, ischemic bowel disease, postoperative states, staphylococcal overgrowth, and bowel obstruction. With the advent of broad-spectrum antibiotics, PME associated with these drugs has generated widespread concern.

It now seems clear that antibiotic-related colitis is a spectrum, with mild diarrhea on one end, and fulminating, fatal PME on the other. The incidence of diarrhea after ampicillin therapy has been stated as 5%,[1] 8%,[2] 16%,[3] and 17.3%[4] in adults and 20%[5] in children. Clindamycin was similarly compared in most of these same studies, and the incidence of diarrhea was consistently higher.

The factors influencing the onset of either diarrhea or PME in either ampicillin- or clindamycin-treated patients are not known with certainty. Both processes have occurred following IV and oral antibiotic administration, but more frequently after the oral route. Lusk *et al*[4]

found a positive correlation for diarrhea with increasing severity of illness, presence of abdominal sepsis, and total dose of the antibiotic. Gurwith,[1] on the other hand, noted only increasing age to predispose to diarrhea, duration of treatment and total dose not being influential. Important clinically is their observation that most patients had the onset of diarrhea after the antibiotic had been stopped, as occurred in the patient presented here.

The incidence of PME after ampicillin therapy must be extremely low, and in all series to date is considerably less than with clindamycin. Tedesco *et al*[3] reported changes consistent with PME on proctoscopic examination in 10% of patients taking clindamycin, but figures from subsequent studies range from 1 to 2%.[1,2,4] Following ampicillin treatment, Robertson, *et al*,[2] reported PME in 0 of 100 patients; Lusk, *et al*,[4] 1 of 138 patients; and Gurwith, *et al*,[1] 1 of 315 patients.

The etiology of antibiotic-related PME is still obscure, with alteration in colonic microbial flora and patient predisposition the most commonly cited underlying factors. Steer[6] found viral particles in colonic mucosal cells following PME related to clindamycin treatment, and felt that the alteration in bowel flora made the colonic mucosa more susceptible to viral infection. Recent research suggests that Clostridium species may proliferate secondary to a selective antibiotic effect, producing a toxin which is harmful to the colonic mucosa. Experimentally, the process has been prevented by early use of a clostridial antitoxin before the onset of symptoms.[7]

Although rare, ampicillin-related PME is a well established entity and speaks for judicious use of this effective antibiotic. Serious questions must be raised regarding its use as prophylaxis and in minor illnesses, and whether treatment should be continued if diarrhea develops.

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Editorials

Arnold to Califano

November 1, 1978

Joseph Califano
Department of HE&W
Washington, DC

Dear Mr. Califano:

In the HEW pamphlet urging second opinions in regard to the need for surgery, the middle paragraph on page 5 says:

"If, as a result of the second opinion, you decide not to have surgery, you avoid the risks, costs and discomfort usually associated with surgery."

I gagged on this choice morsel of bureaucratic oversell. What about adding:

"Of course, you also miss out on the benefits of such surgery, if it happens that the first doctor was right and the second doctor was wrong."

How does HEW propose to avoid being pushed into the position of advising a third opinion, in the event the first two are different? How can HEW conscientiously avoid sharing—indeed, bearing a major share of—responsibility for second opinions which end disastrously?

In one man's opinion, you have overstepped the bounds of ethics, propriety, and good sense, in promulgating and disseminating this pamphlet. We propose to say so editorially.

Sincerely,

HARRY L. ARNOLD, JR., M.D.
Editor

Second, third, fourth and fifth opinions.

Above is a letter: Arnold to Califano, that needed to be written. The subject: DHEW's pitch in a brochure for a second opinion in surgery.

DHEW has put itself in the position of a meddling aunt, uncle or in-law, who takes the baby to a "specialist" in "turned stomachs"—a lay-person who massages the abdomen until the hot appendix ruptures.

Physicians ordinarily are quick to recommend a consultant when the problem is real and the outcome in doubt. Physicians, for the most part, are ahead of the patient and they sense when the latter is about to ask for one anyway. Since Medicine is more of an art than a science, the rapport between patient and doctor, the trust a patient puts in his personal physician, becomes a large factor in therapy. Even though to seek consultation may seem to be an admission of perplexity or of doubt in his own capability on the part of a physician, it is only right and proper for him to share it with his intelligent patient; as partners in problem-solving, both agree to this step in a decision-making process. On the other hand, many a patient needs and would rather have the support of a firm and confident doctor. Each instance is its own special case. Califano would change all this and "regulate" it by cold, cut-and-dried, impersonal methods.

We need to remind DHEW that we already have a system going, particularly in-hospital, that is conducive to consultation, and even to multiple opinions and team care.

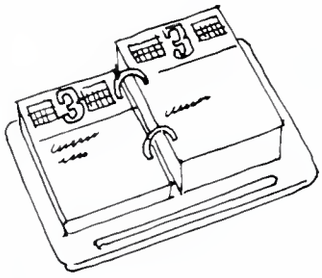
For the government to step in, and by law or regulation, to mandate second, third and fourth opinions in surgery, is to destroy the basic trust and the close personal relationship between patient and doctor that is so essential to quality medical/surgical care.

The intent of the Feds is obvious: "Don't let them operate; it will save money." Carry it one step further, Mr. Califano: "No more CPR; let them all die; it will save money."

However, there is an underlying principle that most people fail to see. That is: "He who pays the bills has the right to call the shots." We are getting a foretaste of how it will be under National Health Insurance. In Workmen's Comp, for example, the employer has the inherent and legal right to have the injured employee, who is claiming a disability, examined by a company-appointed physician. In fact, there are MD specialists now who spend nearly all of their time at this. They have become notorious for being "patient-haters"; their total loyalty is to those who pay them: The employer or the third party payor. And, please remember that the biggest third party payor of all is the Federal Government.

Beware, Califano! You are pushing so hard —in the name of cost-control—for denial of benefits to the people, that you may find yourself in Nero's sandals—fiddling, while Washington burns!

J.I.F.R.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/ Maui Mem. Hsp.

John A. Burns School of Medicine

1. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
2. U.H. Cardiology Grnd. Rnds., 1st & 3rd Tuesday, 5:30 p.m. Rm. 506 Univ. Tower, Queen's.
3. UH Grand Rnds-Ob/Gyn, Wed. 7:30-8:30 a.m. Kapiolani Hsp. Aud.
4. UH Perinatal Conf., Thurs. 3:30-4:30 p.m. Kapiolani Hsp. Rm. 815.
5. UH Seminar, 2:30-3:30 p.m. Kapiolani Hsp. Rm. 826. Fridays, 1st-Pathology; 2nd-Perinatology; 4th-Journal Club.
6. UH Conf., Friday, 3:30-4:40 p.m. Kapiolani Rm. 826.
7. Psychiatry Grand Rounds, 1½ hours credit, Friday 8:00 a.m.-9:30 a.m. University Tower, 6th Floor, 1356 Lusitana Street. Contact: Dr. McDermott at 548-3420.
8. Psychiatry Case Conference, 1½ hours credit, Tuesdays 10:00-11:30 a.m. University Tower, 4th Floor, 1356 Lusitana Street. Contact Dr. McDermott at 548-3420 or Dr. Wen-Shing Tseng.
9. University Medical School Grand Rounds, 3rd Thursday, 4:30-6:00 p.m.
 12/21/78—"Hanson's Disease." Coordinator: Olaf Skinsness. Mabel Smyth Auditorium.

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Kapiolani Maternity Hospital

1. Tuesday Conference, 1:00-2:00 p.m. Kapiolani Hsp. Aud.
 1st—Didactic Presentation
 2nd—Perinatal-Neonatal Topics
 3rd—Obstetrics Topics
 4th—Gyn Topics
2. Neonatal Grand Rnds., Friday 8:00-9:00 a.m. Kapiolani Hsp. Nursery.
3. Tumor Board-Oncology Conf., 1st & 3rd Friday, 1:00-2:00 p.m. Kapiolani Hsp. Aud.

Kuakini Medical Center

1. Visiting Professor Program
2. G.I. Conference, 2nd Tuesday, 8:00-9:00 a.m.
3. Nephrology Conference, 4th Wednesday, every month, 8:00-9:00 a.m.
4. Oncology Conference, every Thursday, 7:30-8:30 a.m.
5. Surgical Conference, 1st, 2nd, 3rd and 5th Friday, 1:00-2:00 p.m.
6. Surgical Mortality and Morbidity Conference, 4th Friday, 1:00-2:00 p.m.
7. Opthalmology Departmental Meeting, 1st Tuesday, every month, 1:00-2:00 p.m.
8. Medical Mortality & Morbidity Conference, 3rd Tuesday, every month, 1:00-2:00 p.m.

(Contact CME Dept.-Kuakini for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium

Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room

3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
6. SFH-UH Surg. Sat. Teaching Rnds. (except 4th) 7:30-8:30 a.m. UH 4 Classroom.
7. SFH-UH Hematology Conf., 4th Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
8. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
9. Tumor Conf., ea. Monday, 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Cardiac Surgery Meeting meets the 2nd Tuesday of the month, from 4:30-5:30 p.m. in the Doctor's Dining Room.
3. Friday Noon Conference meets weekly, from 12:30-1:30 p.m., in the Doctor's Dining Room.
4. Medical Grand Rounds meets the 1st Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.
5. Orthopedic Conference meets quarterly, from 7:30-9:00 p.m., in the Doctor's Dining Room.
6. Quarterly Professional Meeting meets the 4th Monday of the month, from 7:30-8:30 p.m., in the Doctor's Dining Room.
7. Surgical Mortality and Morbidity meets the 4th Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Local Hospitals, Honolulu
Type: 1, 1 hr./day, 1 day/mo. from 12 mos.
Fee: None Methods: AV, O, Pan
Dates: All yr., 12 hrs. instruction

SPECIAL EVENTS

Dec. 6-7-8-9, 1978	Am. Med. Joggers Assoc. 16 hours Cat. 1. Contact: Kent Davenport, M.D. or Honolulu Marathon Assoc., P.O. Box 27244, Chinatown Station Honolulu, 96827.
Jan. 4-6, 1979	Maternal & Fetal Med. Am. Coll of Obstetricians & Gyns., 1 E Wacker Dr., Chicago 60601. At: Island of Hawaii. 2½ days, 16 hrs.
Jan. 8-12, 1979	Echocardiography: A Review of Current Concepts & Techniques. Am. Coll of Cardiology, 9111 Old Georgetown Rd., Bethesda, MD 20014. Cosponsor-U of H John A. Burns Schl of Med., The Honolulu Med. Group Research Found. Held at Wailea Beach Htl., Wailea, Maui. 5 days, 20 hrs.
Jan. 15-17, 1979	Urology for Specialists, Univ. of Ore Hlth Sciences Ctr., Div of Cont Med Educ, 3181 SW Sam Jackson Pk. Rd., Portland, OR 97201. Held at: King Kamehameha Htl., Kailua-Kona, HI. 3 days, 16½ hrs.
Jan. 20-27, 1979	Adv. in Nephrology, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave. LA, CA 90033. Held: Intercontinental Htl, Maui. 5 days, 30 hrs.
Jan. 22-28, 1979	4th Annual HI Hosp. Med. Staff Conf. Estes Park Inst., Box 400, Englewood, CO 80151. Cosponsor: Queen's Med. Cntr. Held at Kauai Surf Resort, Kalapaki Beach, Kauai 96766. 5 days, 30 hrs.
Feb. 1979	Workland Recording Workshops, Coll of Am. Pathologists, 7400 N. Skokie, IL 60077. Held at Sheraton Waikiki, Honolulu. 15 hrs.
Feb. 6-9, 1979	Perinatal Med. USC Sch. of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Royal Lahaina, Maui. 5 days, 19¼ hrs.
Feb. 19-22, 1979	Mid-Winter Traveling Med. Educ. Course, Kansas City SW Clin. Soc., 2220 Holmes, KC, MO 64108. Cosponsor: U of MO-Kansas City Sch. of Med. Held at Maui Surf Htl., Maui. 4 days, 16 hrs.
Feb. 19-25, 1979	Financial Planning/Med & Dental Prac Management, Med Communications & Servs Assn. 1107 NE 45th, S 315, Seattle, WA 98105. Held at: Sheraton-Molokai, Box 1977, Kepuhi Beach, Maunaloa, Molokai.
Feb. 26-Mar. 2, 1979	Surg. Diag. & Therapy, The Phil Thorek Postgrad. Courses, 850 Irving Park Rd., Chicago 60613. Held at Maui. 5 days.
Mar. 6-10, 1979	U of H Sports Med. Course, Schl. of Med. 1960 E-W Rd., Honolulu, 96822. Cosponsor: AAFP. Held at Princess Kaiulani Htl. Waikiki, Honolulu. 5 days, 18 hrs.
Apr. 15-21, 1979	Current Concepts in OB/GYN, Mem. Hosp. Med. Ctr. of Long Beach-Women's Hosp. 2801 Atlantic Ave., Long Beach, CA 90801. Cosponsor: U of CA, Irvine Ctr. for Health Educ. Held at Kauai Surf Htl, Lihue, 06766. 3 days, 24 hrs.
Apr. 15-21, 1979	Diving Med. U of H Schl of Med. 1960 E-W Rd., Honolulu 96822. Held at King Kamehameha, Kailua-Kona, HI. 6 days.
Apr. 21-28, 1979	Emergency Med-1979 USC Sch. of Med. 2025 Zonal Ave. LA, CA 90033. Held at Royal Lahaina Htl., Maui. 5 days, 30 hrs.
Apr. 21-28, 1979	Diagnostic & Therapeutic Skills in Internal Med., USC Sch of Med., Div. of Postgrad., 2023 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.
Apr. May 18, 1979	Orthopedic Review, USC Sch of Med, Div of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.
May 14-18, 1979	Pediatric Workshop, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Royal Lahaina Htl, Maui. 5 days, 28 hrs.

OUT OF STATE

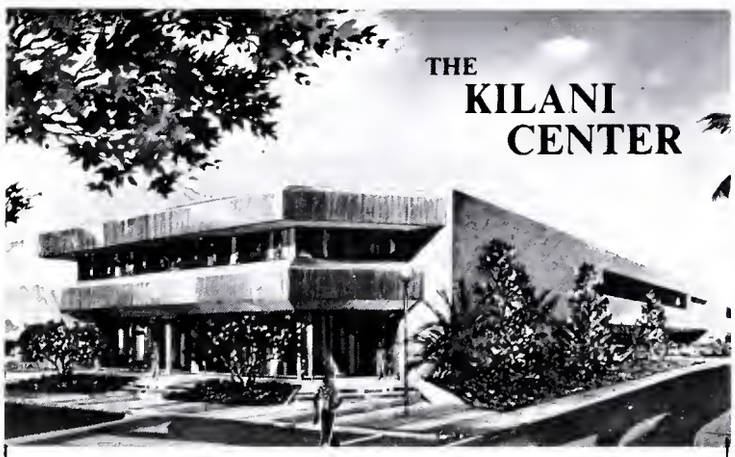
For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.

HMA Council Meeting

Friday, September 1, 1978
5:30 p.m.
HMA Conference Room

PRESENT

Drs. Hanlon, Goto, Bell, Hindle, Mills, Walsh, Stodd, Couch, Kam, Edwards, Lafferty, Fu, Wigle and Bruce plus Mr. Chikamoto and Mrs. Nancy Simmons. HMA staff present were Mr. Won, Mr. Saranchock, Mr. Ajifu, Mr. Ontai, Mrs. Chang and Mrs. Kendro.



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CALL TO ORDER

The meeting was called to order by President Hanlon.

MINUTES

The minutes of the meeting of August 4, 1978 were approved as circulated.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. Cancer: Dr. Keenan briefed the Council regarding the Cancer Committee meeting with Dr. Thomas Hall who has been asked to direct the Community Cancer Program. The Cancer Committee will continue to meet with Dr. Hall.

B. Self Insurance: Dr. Nicholson reported that he had visited with a California insurance carrier who is interested in expanding professional liability insurance coverage for physicians in Hawaii. The Council directed Dr. Nicholson to explore the possibility further and to report back to the Council.

C. Voluntary Effort: Dr. Mills reported on the activities of Hawaii's Voluntary Cost Containment Committee and the need for HMA participation. He noted that the hospitals are contributing toward the financial operation of the Committee based on the number of beds in their institutions and recommended that the HMA contribute $2,500 immediately and to include $2,500 in the 1979 budget proposal. The Council agreed with Dr. Mills' recommendation.

D. Building: Mr. Won reported that the building operations are going well and that many of the activities for obtaining a mortgage have been completed.

E. Publications: At the August 1978 Council meeting, the Publications Committee recommended a special student rate of $6.00 for subscriptions to the HAWAII MEDICAL JOURNAL. Based on the cost information prepared by HMA's accountant, the Council agreed to approve the recommendation.

F. Finance: The financial statement for the month of July 1978 was circulated and approved subject to audit.

1979 BUDGET PROPOSAL

Dr. Hindle reviewed the proposed 1979 budget and recommendations to the HMA House of Delegates.

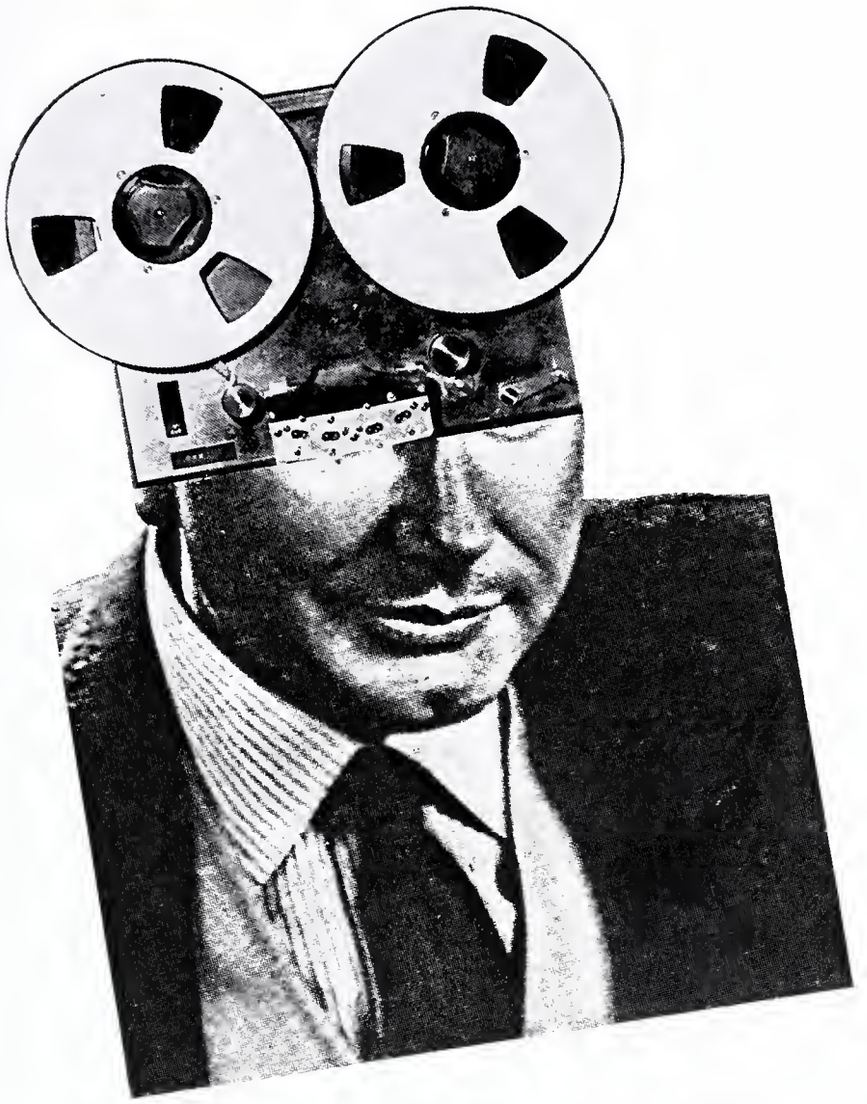
ACTION:
It was voted to forward the proposed budget to the HMA House of Delegates.

NEW BUSINESS

A. Request from Hawaii Educational Council: Mr. Won reviewed a proposed management/leadership conference for physicians and others in the health care field. It was agreed that HMA would help in the publicity of the program.

B. FEC Subpoena: Attorney Chikamoto reviewed the circumstances regarding the subpoena filed against the HMA by the Federal Election Commission claiming that the HMA, HAMPAC, and AMPAC are affiliated and in violation of the campaign spending law.

ACTION:
It was voted to authorize Mr. Chikamoto to proceed with the alternatives to be taken up to a limit of $3,000.



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ADJOURNMENT

The Council voted a special vote of thanks to Dr. Marion Hanlon for his patient manner, good humor and efficiency in serving as president of the Association. The meeting adjourned at 9:30 p.m.

DOUGLAS B. BELL II, M.D.
Secretary



Blood Cultures

The proper collection of adequate volume of blood and number of specimens is essential in the detection of bacteremia. Where the bacteremia is usually continuous, such as in endocarditis, brucellosis and typhoid fever, the timing of sample collection may not be critical. However, most clinically significant bacteremias are usually intermittent and precede the fever or chills by about one hour. Since it is impossible to predict this sequence of events, more than one blood sample must be cultured. Three or four separate blood samples over a 24-hour period should be sufficient in most infections.[1] For best results, the blood should be collected at intervals of at least one hour or more.

A general guide to blood collections is as follows:[2]

1. For severe life-threatening clinical septicemia:
 Two 10 ml blood samples by separate venipuncture immediately before starting treatment.
2. For suspected low-grade intravascular infection such as SBE:
 Three 10 ml samples within the first 24 hours at intervals greater than one hour.
 Some authors recommend three more samples on the next day, especially in patients where the first cultures are not positive by the second day or when there is a vague diagnostic problem.[3]
3. For suspected bacteremia in patients already on therapy:
 Four to six cultures within the first 48 hours. The blood sample should be collected just before the next dose of antibiotic.

Contamination of blood cultures is a frequent problem, but the type of organism isolated correlates with bacteremia or contamination.[4] Organisms isolated only in bacteremias were pneumococci, Group A streptococci, enterobacteriaciae, bacteroides, hemophilus and candida, while organisms found only in contaminated cultures included diphtheroids, bacillus and nonhemolytic streptococci. Some organisms were found in both situations. Although coagulase-negative staphylococcus was the most common contaminant, it also caused bacteremia but only in patients with an intravenous foreign body. Alpha hemolytic streptococci were found in patients with intravenous catheters and in drug users with endocarditis. Multiple organisms were found in drug-users, leukemics on chemotherapy and neonates with amnionitis.

The most common sources of bacteremia in descending order are the respiratory tract, genitourinary tract, abscesses and surgical wounds and the biliary tract.[5]

REFERENCES

1. Washington JA II: Blood Cultures, principles and techniques, Mayo Clinic Proc 50:91-93, 1975.
2. Bartlett RC, Ellner PD, and Washington JA II: Blood Cultures, *Amer Soc Microbiol*, October, 1974.
3. Bartlett RC, and McCarthy: Detection of Bacteremia, Pfizer Diagnostics "Dialogue," Annual Meeting of ASM, 1974.
4. MacGregor RR, and Beaty HN: Evaluation of Positive Blood Cultures, *Arch Int Med* 130:84-87, 1972.
5. Reller LB: Bacteremia: Its Clinical Significance and Guidelines to Productive Cultures, B.D. Lab Notes, 3:5-6, 1978.



The Last Sex Manual

By Ron Pion, M.D., with Jerry Hopkins. 241 pages. Simon & Schuster, New York, 1977. Price: $10.95.

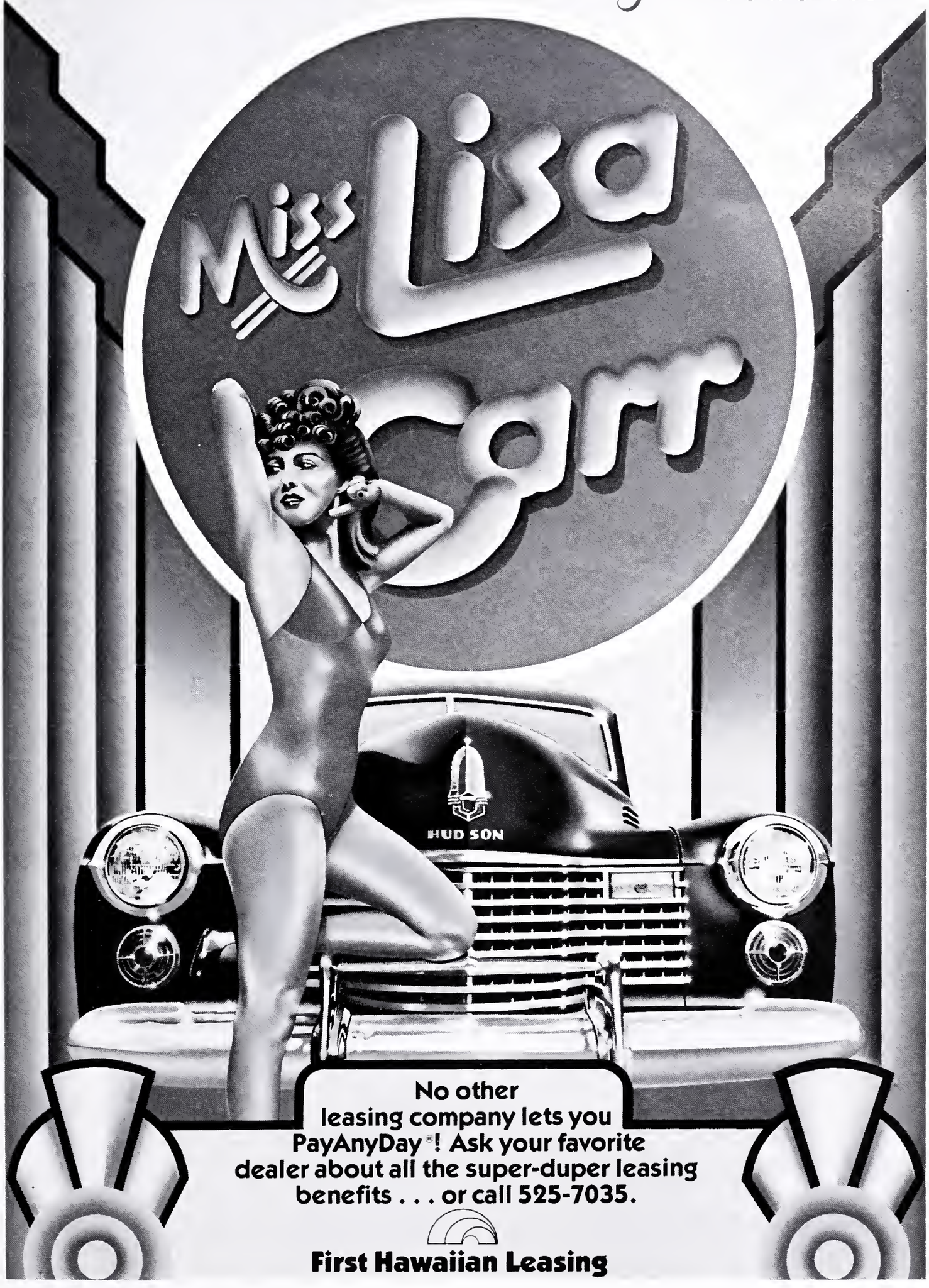
This is a different sex manual. The problems aren't different, but the solutions are. Dr. Pion has applied the fundamental principle of the eastern martial arts to the solving of sex problems: using the other fellow's momentum to master him. Not against him, but to help him to help himself by doing what already comes naturally. For **him** and **himself,** read also **her** and **herself.**

He teaches patients to make good practical use of their assets (which they have often failed to recognize as such) and to take a different view of what they have perceived as their liabilities. The result is a great deal of success, and the book has many instructive and detailed testimonials from individual patients.

It may not be the **last** sex manual, but it sure as heck isn't just **another** one!

HARRY L. ARNOLD, JR., M.D.

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Hawaii Academy of Family Physicians' Newsletter

J. I. Frederick Reppun, M.D.

New Members—none this time.

News of Members—Harold Machigashira was also at San Francisco; he received the degree of Fellow at the convocation. Congratulations, Harold! **Roscoe Pebley** has transferred to the Kansas Chapter and is living in Bonner Spring. **George Gay** was with the Hilo Med Grp but went back to California recently. Dean Terry Rogers of UHSM and 12 others were inducted into the prestigious Omega Alpha; among them were Student Members **Denzer, Sackett** and **Warren.** Congratulations! Both newspapers featured the dedication of the "new" Wahiawa General Hospital. Featured were members **Rod Miller, Ernest Santos, Norby Baysa** and **Richard Tesoro. Pat Dietrich** was one of the speakers before a class at the East YWCA on 20 September.

October DINNER MEETING—on the 28th featured speakers Michael Weiner MD on plastic surgery and Michael Mazzola on a Financial Game Plan for Doctors and Others called X-elan. Believe it or not, 14 yellow cards were collected. 25 members attended and 51 people in all enjoyed the hospitality of **Larry** and **Joan Wong.** Non-members John Aoki MD, Paul Martin MD and Robert Todd MD from TAMC were there, as was **Don Newman,** member from Molokai. We were happy to see **"Charlie" Cachero** and wife join the crowd, plus newcomer and member **Mona Bomgaars** from the UHSM faculty. Student members **Ling, Morioka** and **Ragunton** swelled the crowd.

ANNUAL MEETING—plans are jelling. **Dave Swanson** has succeeded in getting Noble Butler, Ph.D., Chief of Education at the Family Institute of Chicago/Center for Family Studies and Ass't Prof. Clinical Psychology at Northwestern Univ. Medical School to come to Hawaii to hold a "Mini-workshop in Family and Marital Therapy" on 27 and 28 January 1979 for 12 "P" credits (applied for) at a location to be announced. This will be in conjunction with our Annual Meeting and dinner at the Ilikai on Saturday 27 January 79. The workshop will be from 9 to 12 and 1:30 to 4:30 each day.

DUES—the Congress of Delegates in San Francisco did not raise national dues this coming year, and the Hawaii Council followed suit. Active dues are $100 National and $20 Hawaii, Practicing Affiliate $15 and $15, Resident Affiliate $15 and $10, Student Affiliate $5.00 and $5.00, Sustaining $100 and $20, Life $10 and $5, Inactive $15 and $5.

Reminders of CME—coming up next: Tennessee's "Update '79 in Hawaii" at the Hilton Hawaiian Village 26 Dec 78 to 2 Jan 79.

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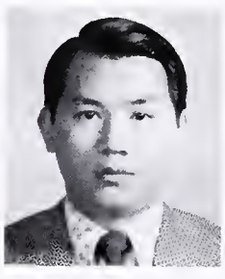
PERSONNEL-ITY OF THE PACIFIC

Sincerely,
Paul S. Isenburg, Ph.D.
Director
Medical Services

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New Members



Frank Dawcheng Chang, M.D.

1741 Nuuanu Avenue
Honolulu, Hawaii 96817

ANESTHESIOLOGY



Neill S. Hirst, M.D.

888 South King Street
Honolulu, Hawaii 96813

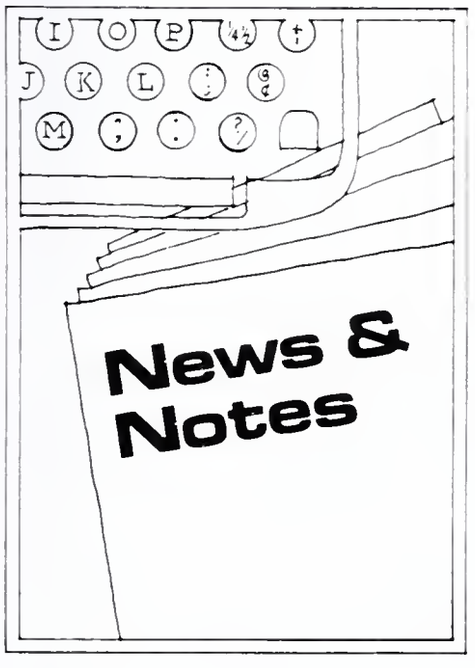
NEUROLOGY



Victor Ho, M.D.

888 South King Street
Honolulu, Hawaii 96813

PEDIATRICS



HENRY N. YOKOYAMA, M.D.

Professional Moves

We are forever misplacing announcements and so we must backtrack to September . . . Straub Clinic added neurologist **Neill Hirst,** pediatrician **Victor Ho** and FP **David Evans** . . . Kaiser Permanente Program added pediatrician **Cynthia Nakasato** while The Fronk Clinic, Pearlridge signed up general surgeon **Werner H. Grebe** . . . Psychiatrist **Carol Brown** joined **Lynda Howlett** for the practice of adult and adolescent psychiatry in the Aina Haina Professional Bldg while another psychiatrist, **Frances Cottington,** relocated to the new Century Center Suite 3201 at 1750 Kalakaua Ave . . . Surgeon **Robert Oishi** opened a branch office at the Aiea Medical Bldg and radiologist **Richard Wang** opened a Waipahu Office at Suite 101, 94-239 Waipahu Depot St.

On to October . . . Dermatologist **Joseph Hathaway** who presumably retired many years ago and even did part-time real estate selling was back in the medical harness and has joined **Claude Caver** in Suite 401, Queen's Physician Office Bldg . . . Pediatrician-nephrologist **Mitsuaki Suzuki** has relocated to the Waimalu Shopping Center . . . Internist-cardiologist **Stephen Wallach** opened at 848 So Beretania; neurosurgeon **John Henrickson Jr.** opened at the Kukui Plaza Mall, Suite C-211 and FP **Dorothy Whittaker** has joined the Koolau Clinic of the Kaiser-Permanente Program . . . In West Hawaii, Kona Medical Associates announced that internist **Pachnee Pathomvanich** has joined its Kailua and Kealakekua office . . .

In early November, dermatologist **William Wong** opened his office at the Aiea Medical Bldg "to treat diseases of the hair, skin and nails" while over in Kailua, Hawaii a **Rudolf Nuunemanu** opened at 415 Uluniu St to limit his practice to adult and pediatric urology . . .

When **Leslie Koch** retired, DOH Director **George Yuen** appointed **Erida Reichert** as his new Hansen's Disease facility director for patients at Kalaupapa and Leahi Hospital . . .

Claude Caver's Witticism

"You know what Hawaiians call the new Pope?" John Paul 'i'i.

First official act of the new Polish Pope was to have the Sistine Chapel ceiling painted.

The Indian chief had three squaws from different tribes all trying to become his favorite . . .The first squaw gave birth to a baby boy and as was her tribal custom, wrapped the baby in antelope hide and presented him to the chief . . . The second squaw also gave birth to a baby boy and as was her tribal custom, wrapped him in buffalo hide . . . The third squaw went one better and gave birth to twin baby boys. And as was her own tribal custom, she wrapped them in hippopotamus hides and presented them to the chief, who was most pleased . . . thus proving that "the squaw of the hippopotamus is equal to the sum of the other two hides . . ."

A raggedy confederate outfit captured a union army supply train in Richmond. Alas, there were no provisions or ammunitions on board except for brand new union army blue uniforms. The confederate commander had a chemist test various dyes and bleaches on the union blue, but the old dye formula would not bleach. Finally the commander ordered his troops to remove their tattered confederate gray and wear the blasted union army blue uniforms. Soon, the

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soldiers' sweat and exposure to the sun bleached the uniforms to the proper confederate gray . . . Which goes to prove that "Old dyes never fade . . . They just soldier away . . ."

Life in These Parts

Interesting bumper sticker: "Watch my rear end, not hers!"

One sparkling bright day after a week of heavy rains, we followed an unwashed yellow Chevy van on Kapiolani proceeding Waikiki . . . The entire lower half of the van was covered with reddish dry mud found only in one part of the island, but some mischievous wit had taken away the fun of guessing by carefully finger painting in bold letters: **"I'M FROM WAHIAWA."**

HARDY, COMPASSIONATE SOUL . . . We sent a brief note to newly elected HMA Prexy **George Goto** and received the following handwritten note: "Dear Henry, Thanks very much for your get-well note. I'm doing fine and am able to attend most of the HMA meetings. I'm walking 2.7 miles in 53 minutes three times a day. In another day or so I'll be doing 3 miles in 1 hr three times a day . . . I can understand why you want to take a breather from the chairmanship of the TV Radio Committee . . . Thanks again for your sentiments . . . Sincerely, George" (Likeable, hard-working George had a mild MI just before the annual HMA meeting in October and we all worried for him.)

ALOHA UNITED FUND . . . Poor **Myron Shirasu** . . . He's being called "Houdini" because he makes doctors disappear . . . Whenever he walks down the hospital corridors, congregated doctors quickly disappear before he can start his pitch . . . Myron is chairman of the Doctors Division of the Aloha United Fund. Thanks to his doggedness the physicians reached their quota of $75,000, which in itself is a miracle (according to equally dedicated **Paul Tamura,** Professional Division Chairman of the United Fund) because we had still 30% of our quota to reach one week before the deadline . . . So Myron is "Houdini," not only because he makes doctors disappear, but because he is capable of squeezing water out of rocks . . . Unfortunately the lawyers who had the same quota beat our 100% with their 106% . . . Oh well, we tried . . . or rather the following dedicated physicians tried: **Richard Tesoro** canvassed Wahiawa, **George Shimomura** Waipahu and Waianae, **Ham Winston** and **Winfred Chang** Kailua and Kaneohe, **Tom Cahill** Aiea and Pearl City, **Arthur Sprague** his fellow anesthesiologists, **George Nagao** his fellow pediatricians, **Eugene Kostiuk** the psychiatrists, **Neal Winn** his fellow OB Gynecologists and the Kapiolani Office Bldg, **Cal Miura** his fellow ophthalmologists, **Pat Okamura** the emergency physicians, **Ann Catts** her fellow pathologists and part of Queen's POB, **George Kenessey** the American Security Bldg, **Allan Izumi** and **Al Chun-Hoon** the Queen's POB, **Bob Kistner** the Straub Clinic, **Yi-Chuan Ching** the Kaiser Foundation, **Gerald Hiatt** the Fronk Clinic, **Pat Walsh** and **David McEwan** the Honolulu Medical Group, **Walter Chang** the Chock-Pang Bldg, and **Douglas Bell** the Ala Moana Bldg . . .

"Catch 22: Move to aid elderly may cost them health benefits." The DOH is finding that bureaucracies generate tape and occasionally the tapes get snarled . . . When the Lavada Care Home was closed in September by the DOH for poor facilities and unsanitary conditions, it moved the 35 elderly patients into a renovated building at the Hawaii State Hospital. In doing so, the DOH unwittingly jeopardized the patients' eligibility for SSI (Supplemental Social Security Income) as well as Medicare and Medicaid benefits because a federal regulation prohibits benefit payments to persons living in a state facility with more than 16 residents . . . **John Chalmers,** who heads the DOH's care home licensing branch, plans to meet with regional administrators of SSI, Medicare and Medicaid programs in San Francisco and ameliorate the situation pronto . . .

Leon Speroff, chairman of the OB Gyn Dept, U of Oregon School of Medicine, lectured at the 122nd Annual HMA Meeting and advocated estrogen therapy for post menopausal women because the benefits outweigh the risks involved . . . Leon feels that properly monitored estrogen therapy with progesterone can totally prevent and even reverse osteoporosis at any age . . . "When a patient is placed on estrogen, their risk of endometrial cancer goes from 1/1000 to 4 to 8/1000, but the risk is greatly reduced by adding progesterone (Provera) . . . As for breast cancer, there has been only one paper indicating there is a potential risk by using estrogen."

For the past 6 years Duke Cho Choy, Kailua pediatrician, has been conducting a Chinatown Free Medical Clinic on Thursday evenings from 7:30 pm . . . It all started when his daughter Diane, an organizing member of the clinic, asked him to help . . . Duke is no stranger to free volunteer clinics, for in the past he has been involved with the Waipahu Health Clinic and the Waikiki Drug Clinic . . .

Hog Viscera Facing Ban Again . . . Crusading pediatrician **Wayne McKinny** may have done it again. Wayne has been raising such a ruckus about the rise in Salmonella rates in Hawaii (8-10 times the national average) as related to hog viscera (which is an ethnic delicacy), that a Leslie Rafoth, director of the Western Region, U.S. Dept of Agriculture's Meat and Poultry Inspection Program who praised the State's new pasteurization process, has still raised the prospect of renewed ban on hog viscera . . . (Well, there goes some of our favorite oriental delicacies.)

"Plenty of politicians must feel like hamburgers when they sign-wave . . . Especially Dr **Richard Ando**—He's been splashed twice by the notorious 'Ketchup Squirter' at the East Manoa triangle . . . Last time they sprayed ketchup on him, it took 5 minutes before he could start smiling again . . ." (Daacon 10/13) (Dear Dick: "Ketchup Squirter" or not, please keep smiling and try again . . . You were up against tough competition and we thought you did very well for a first go at the Senate . . .)

In the wake of at least 7 cases of *ciguatera* poisoning in Pokai Bay, Waianae from eating small reef fish, Robert Melton, Kauai District health officer, reported that a westside fisherman may have died from eating a small sardine and warned Kauaians not to eat these small sardines, esp their viscera and heads where the toxin is concentrated . . .

Henry Yim, chairman of the Hawaii Chapter of the American Academy of Pediatrics, announced a national and statewide program called, "Speak Up for Children." The program will start in January . . . and is intended to be "conciousness raising for the total health and welfare of children." The UN has designated 1979 as the "International Year of the Child."

The DHEW's Bureau of Developmental Disabilities has awarded the U of H School of Medicine $167,316 as a one-year grant for a university-affiliated training satellite center. **Sharon Bintliff** will head the program . . .

AMA prexy **Tom Nesbitt** was here for our 122nd HMA Convention. Tom reported that 92% of the American people have health insurance policies and that we need to target in on the 19 million who have no insurance—mostly those unemployed, small business people and those who run "mom-and-pop" stores. Tom suggested that minimum standards for health insurance programs be set by each state through a state insurance commissioner since health care standards vary from state to state . . . Regarding the recent statement of HEW Secretary Joseph Califano that patients should seek a second opinion for non-emergency surgery, Tom said the AMA has always encouraged patients to seek second opinions and that this should not be mandatory, but voluntary. The 10 principles that Califano lists are consistent with the 17 principles that the AMA has already listed for the health plans for our nation . . . "We feel health insurance for the American people is utterly proper" . . . Regarding Califano's cost containment plan for hospitals, Tom says, "It is far better to use the principles that govern the free enterprise system to control inflation than to set mandatory wage and price controls." Tom points out that the hospitals are already reducing the spiraling costs of inflation without sacrificing the quality of medical care. "Califano's assertion that voluntary controls will not work is hypocritical and politically motivated . . . Is 8.6% of the gross national product too much for Americans to pay for health care? The cost of government eats up 23% of the gross national product and I'm not too sure 8.6% is too much

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to pay for health care, if we can pay such a price for government . . ." Touché!

With the prospect of a $108 million Medicaid bill facing the State, Robert Millar, medical care administrator of DSSH, says the department proposes to drop most over-the-counter medications from Medicaid coverage. "We're going to insist on the use of generics whenever generics are available . . . With Medicaid costs continuing to climb, we have to knock off frills and get down to basics . . . I don't think taxpayers can stand the bite forever . . . Unless I can cockroach money from some areas and save money in others, we will be over what was budgeted plus the deficiency appropriation when increased hospital costs were not added in . . . "

In late September, first two persons, then five more were ill after eating fish caught in Waianae's Pokai Bay. Symptoms were those of *ciguaterra* viz nausea, vomiting, abdominal pains, diarrhea, aches and pains, strange sensations around the mouth and throat and in more severe cases, respiratory failure and coma. The fish involved were bottom-feeding fish, especially mullets. **Fred Dodge,** Waianae Comprehensive Health Clinic director, reported that two of the victims were being treated at Queen's Medical Center and that Waianae police were warning the fishermen in the bay. **Ned Wiebenga,** state epidemiologist, remarked, "As a precaution, the Health Department recommends that no fish taken from the Pokai Bay area be consumed and that it should be noted that heat does not destroy the poisonous toxins, so it doesn't matter how well the fish are cooked."

Elected, Appointed, & Honored

We congratulate **Fred Gilbert,** Straub physician and medical director of the Pacific Health Research Institute, for his election to the prestigious Institute of Medicine of the National Academy of Sciences. Fred is being honored for his efforts to improve health care accessibility, in reducing health care costs and improving health care quality as well as for his research in heart disease and breast cancer through the Pacific Health Research Institute . . . We can't think of anyone more deserving of the honor . . .

At the HMA's annual banquet, our amiable, quiet achiever, **George Goto,** was installed as president . . . George succeeds hard-working **Marion Hanlon,** outgoing president, who has done a tremendous job also in his quiet way . . . **Douglas Bell II** was elected president-elect and **Neal Winn,** secretary. Oahu councilors are **Nadine Bruce, Thomas Cahill, Bernard Fong** and **Philip McNamee,** and Kauai councilor is **Thatcher Magoun.**

Honored at the annual banquet was **Morton Berk,** retiring cardiologist, who was named "Physician of the Year." Mort was recognized for his multi-faceted roles as founding member of the Hawaii Heart Association, chairman of the 6th Annual Asian-Pacific Conference, board member of the Honolulu Blood Bank, *etcetera etcetera* . . . Name it and he has been involved in it his long illustrious career . . . Even after retirement, we doubt that he will remain idle much . . .

The Hawaii Medical Library at its recent annual meeting elected **Charles Judd Jr.** president, **Henry Oyama** first vice president, **Albert Yuen** 2nd VP, and **Norman Goldstein** secretary . . . Physician members of the board include **Niall Scully, Fred Shepard, Robert Wilkinson** and **Irwin Schatz** . . .

Kauai's **William Goodhue** was honored at a testimonial dinner at the Hanapepe Recreation Center. **R.S. Weiner** welcomed everyone and **Y. Miyashiro, W. Foster,** and **T. Fujii** were testimonial speakers . . .

Tan Theresia of Waipahu, U.H. Med School assistant clinical professor and Kaiser Hospital staff member, was elected to fellowship in the American Academy of Pediatrics . . . Dean **Terence Rogers** and 12 of his medical students were inducted into the U.H. Chapter of Alpha Omega Alpha, national honorary medical society. Interim officers of the chapter are **Clifford Straehley,** president; **Richard Mamiya,** VP; **Richard Blaisdell,** secretary-treasurer and **Sharon Bintliff,** councilor . . .

Cancer Front: The Maui Unit of the American Cancer Society installed **Donald Dietrich** as president, **Russell Stodd** as VP and **Alice Broadhurst** as board member . . . The Hawaii Division of the American Cancer Society installed **Francis Lock DDS** president, **Reginald Ho** VP and as physician board members: **Drake Will, Manas Ghosh, Robert Weiner** and **J. Henry Hoffman** . . .

Miscellany

A young man asked an older man, "What do you lose when you get older?"—half expecting to learn that one loses his golf touch or poker skill. Instead the older man replied, "Well, the other night, I yelled to my wife, 'Honey, I'm coming over!' and she yelled back, 'You came over an hour ago' . . . That's what you lose when you get older." (As told by **Paul Condit,** our Oklahoman oncologist)

The 96-year-old farmer and his 95-year-old wife came into town to see a divorce lawyer. They had been married for 65 years. The husband explained how he could never stand her constant nagging, her lousy cooking and her lack of sexual ardor . . . The wife was equally vehement about his laziness, his sloppiness, and his snoring all their married life. The lawyer asked curiously, "Why did you two wait until now to get divorced?" "Well," they explained, "we had to wait till our six kids were dead." (Another Paul Condit joke)

Hors de Combat

The nation's chief drug fighter, Peter Bensinger of the Drug Enforcement Administration, feels that present laws providing up to 5 years' imprisonment are not doing the job and is asking for stiffer sentences (triple the maximum sentences for marijuana smugglers). He cites talks with the American Cancer Society and AMA that "marijuana actually is a greater cancer risk than cigarettes . . . Comparing marijuana use and alcohol, the key difference is that marijuana accumulates in the blood stream up to 30 days while alcohol dissipates in an hour." There is increasing concern about the burgeoning use of marijuana by the 12 to 17 year-olds . . . National Institute data shows that 25% more youths in this age group use the drug . . .

Anne Trimble offered a free Stop Smoking Clinic on Maui with lectures and discussions by physician **Michael Savona,** psychiatrist **Carlos Greaves** and naturopath **Christian Schmidt.** The Clinic was sponsored by the American Lung Association of Maui, with the cooperation of the American Heart Association and the American Cancer Society . . . The program takes a positive approach and for those who quit and start up again, the encouraging slogan goes, "If you succeed once, quit, quit, quit again!"

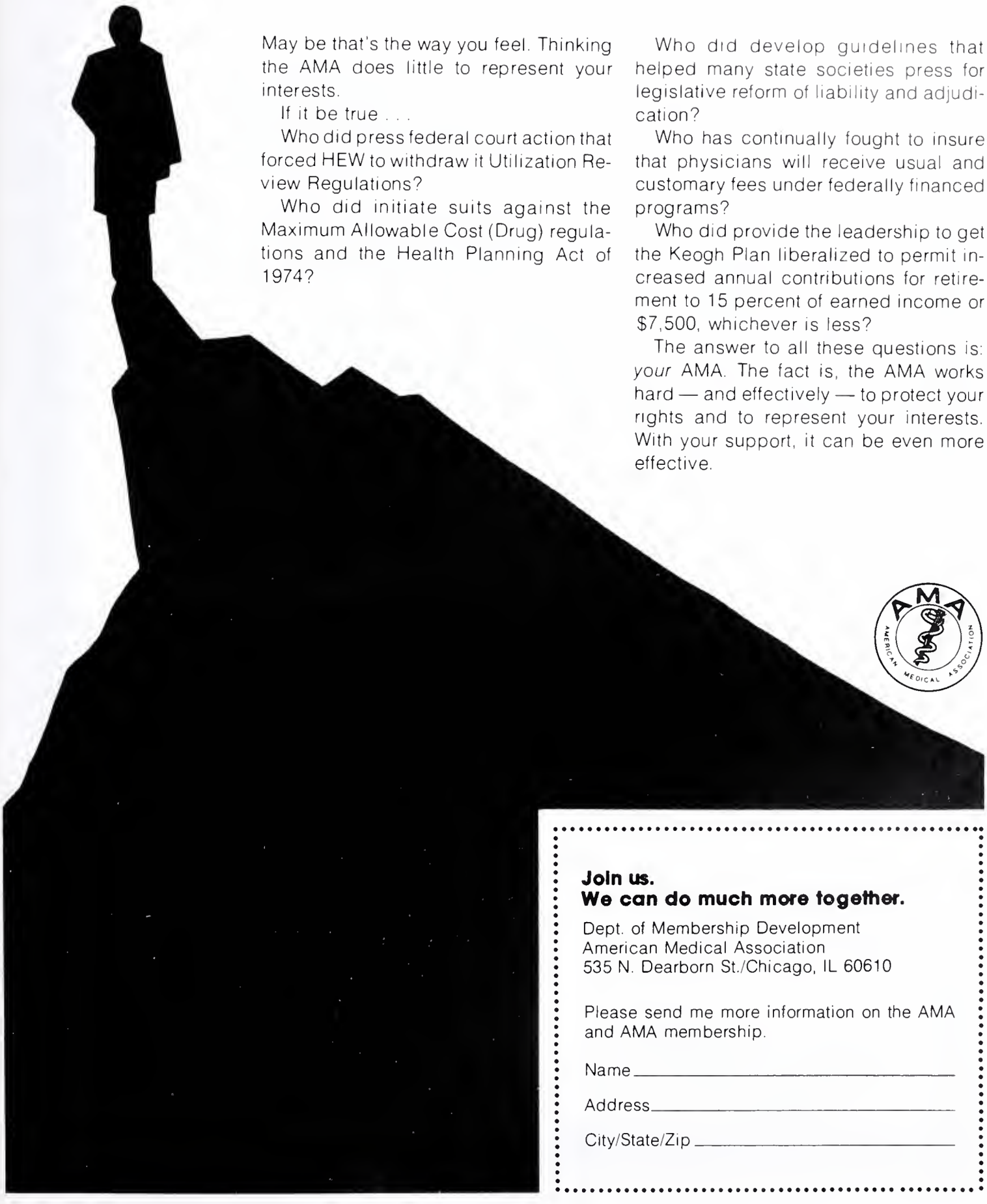
Pete Okumoto was absolved of negligence and a $400,000 malpractice judgment was granted against Hilo Hospital by Honolulu circuit judge Robert Won Bae Chang following a 6-week trial. The $1 million suit against Pete and Hilo Hospital resulted when a youth died of a heart attack following a routine tonsillectomy in August '73 . . . Poor hospital monitoring was given as reason for the judgment . . .

Sportsmen

In the wake of **Jack Scaff** and his successful Honolulu Marathon Clinic, along comes a swimming counterpart for the non-runners. A Jan Prins is organizing a "Stroke Clinic" for recreational and masters swimmers. The clinic plans to branch out into rehab and preventative medicine. Team physician is **Tom Cashman,** Straub pediatrician who is in the preventative medicine program at Straub. The Stroke Clinic will be held on Saturdays from 10 am at the new UH swimming complex . . .

HMA Tournament Winners: Tennis Singles Champ: **Benjamin Chang;** Tennis Doubles Champions: **Benjamin Chang** and **Gerald Dericks** . . . Deep Sea Fishing Tournament winner: **Fred Fong** . . . Ping Pong tournament winners: Singles Champ, **John Spangler;** Doubles Champs, **John Spangler** and **Philip McNamee** . . . Skin Diving Tournament

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winner: **Richard Tessoro** (who speared an 18-lb "Papio" at a depth of 25 feet with only skin diving equipment and breath running out fast . . .)

"After a series of letters, Margo St James, chairmadam of the Frisco Prostitutes Union, 'Coyote' has finally agreed to run in December's Honolulu Marathon. Margo, who may not win the race, but is sure to be the 'fastest' woman in it told **Jack Scaff** that she'll be available to speak to any group that wants to hook her . . . The Marathon, incidentally, already has 5,000 entered and that number may rise to 6,000 (double last year's) by the entry cut-off date." (Daacon Oct 18)

Joggers vs. Runners . . .

Advertiser columnist and world class marathon runner Mike Tymn has been sniping at **Jack Scaff** and his Honolulu Marathon. Mike feels that the glut of everyday joggers clutters up a race and ruins it for serious runners. He brands the Honolulu Marathon "a very antiseptic race" because of the flatness and the many aid stations offering drinks and sponges . . . Jack Scaff, in turn, has accused Mike of trying to kick the little guy off the streets so Mike and other competitive runners can have the marathon to themselves . . . Tymn says: "What it boils down to, is that Scaff is teaching people to run with the heart as a gauge. In racing, you go beyond that . . . You go with guts . . . If you want to race, then race. If you want to frolic, jog along and smile at the people." *(Honolulu Magazine)*

Bill Moore got his dander up at this and wrote in Honolulu magazine, "As a physician and novice runner, I am firmly in Jack Scaff's corner. We have far too many spectator sportsmen already so it's a pleasure to see all the runners each evening around Honolulu." Bill suggests that Tymn's runners start earlier at 6 am and "those of us who run for fun can leave in a companionable bunch at 7 am."

The following are excerpts from Jack Scaff's Letter to the Editor dated Sept 15 explaining the difference between jogging and running: "Man is a biped animal to whom walking is natural. Walking is two-dimensional (width times distance) while running adds a 3rd dimension (height) in that the trailing foot is airborne just prior to the leading foot striking the ground. Like Icarus, in that brief moment of time, man is airborne whereas the walker is limited to the confines of his two-dimensional world . . .

"Jogging may or may not be somewhere in between, but I am somewhat reluctant to develop euphemisms to describe what has been legally defined by the AAU and the Olympics Committee . . . I know I have been accused of feuding with Tymn: however, I do not consider corrections of spelling, pronunciation, syntax, grammar or standard definition a feud, but rather simply, homework . . . Running is an important subject with many areas of uncertainty. It does not, however, allow a columnist to completely rewrite and define running to his own pleasures and prejudices . . ."

Marathoner-cardiologist **John Wagner** was quite disturbed by columnist-cardiologist **Michael Halberstam's** statement: "One thing is certain, 5 or 10 years of heavy jogging—5 or more miles a day—one increases the damage arthritis does to the knees." John writes: "There is not a single valid study in the entire medical literature that statistically proves this . . . In fact, at least 3 well-documented studies show that long distance runners have less degenerative arthritis than the average population and that bone age actually decreases as physical activity increases . . . In general, I find his attitude one of keeping medicine in the rut that it has been in recent years . . ."

The Non-Runners:

Extracted from a witty book review by a John Leo in *Time* magazine Nov. 6, '78 entitled "Running Gag" . . . A review on "The Non-Runner's Book" by Ziegel and Grossberg: "Non-running is America's most popular form of recreation. Nearly 200 million engage in the sport each day and many are said to devote entire weekends to remaining stationary. Marathon non-runners find their bodies crave more and more non-running each day—much like a physical addiction. There is, of course, a 'wall of pain' that must be broken through and many reach it while watching their 14th consecutive football game on television. Another insider phenomenon is 'non-runner's high,' a surprising state of near spiritual exultation, usually achieved at a neighborhood bar. Alert social scientists have noted the clannish aspects of the sport—the exchange of conspiratorial winks among non-runners, the wearing of cultish garb, the familiar claims of moral superiority . . ."

Our "Angels"

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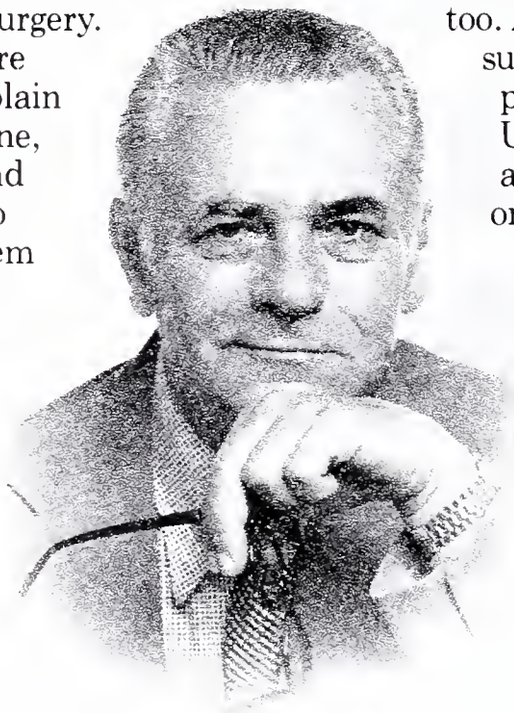
From what our HMSA members tell us, more doctors seem to be perfecting that old fashioned 'bedside manner.'

To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk about these important matters.

We think these are both healthy signs. We can all do our part to promote this kind of helpful dialogue.

We'd like to hear from you, too. Anytime you have a suggestion or question, please let us know. Usually we can have an answer for you in a minute or two.

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Old Fashioned Dialogue is Back.

HMSA Utilization Review Department
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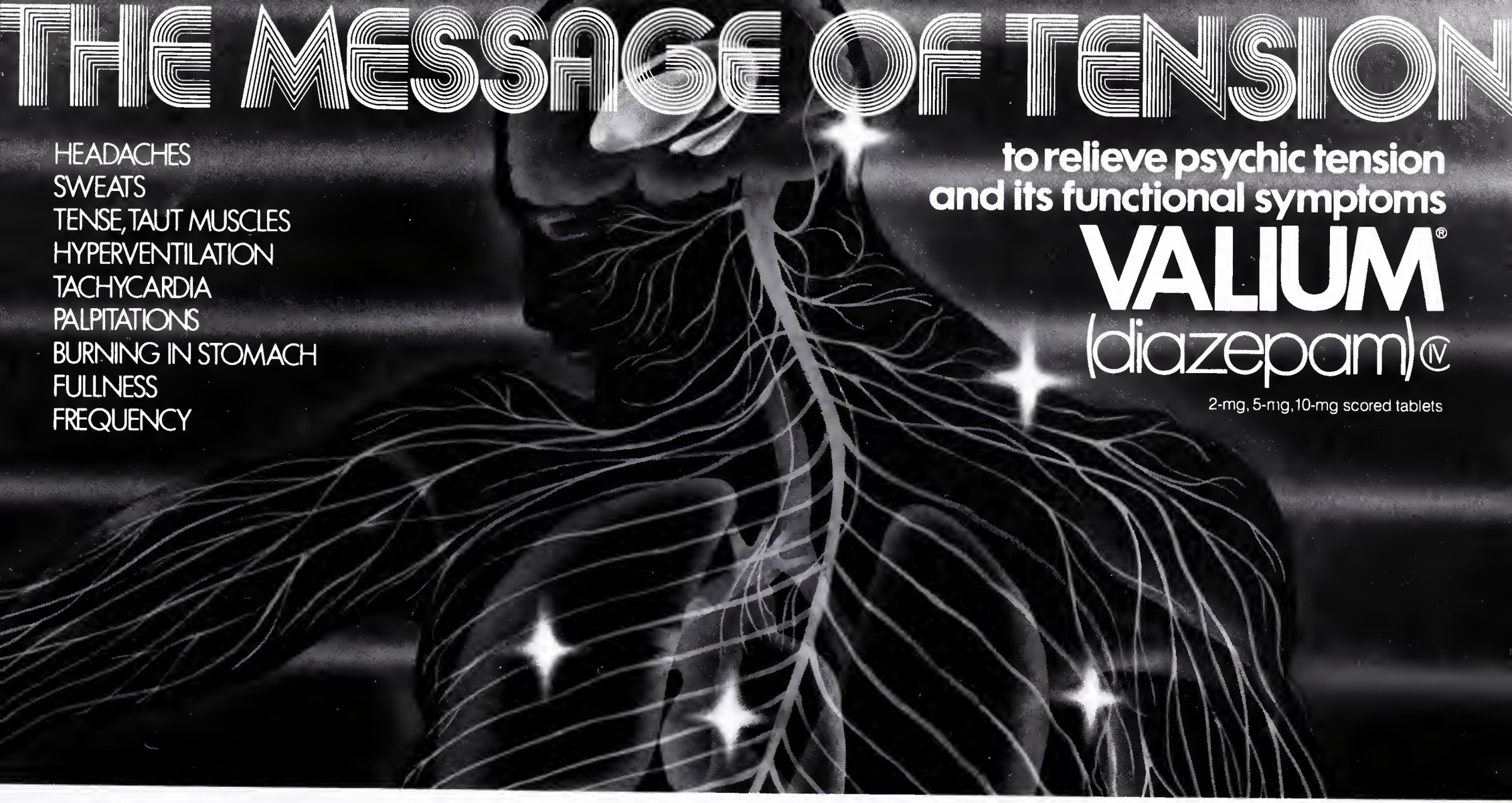
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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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Harry Arnold, M.D.
Editor
HAWAII MEDICAL JOURNAL
320 Ward Avenue
Honolulu, Hawaii 96814

Dear Doctor Arnold:

On reading your *Arnold to Califano* letter, I am reminded again how frequently we find the preposterous becoming commonplace.

Item: a group of seven physicians in Wahiawa outgrew their small quarters, and after searching for several years, recently leased a bigger place three blocks away. Because their move meant spending "more than $150,000" (for walls, furniture, and fixtures), they couldn't move a single examining table until they filed a "Certificate of Need" with the local bureaucracy. This "CON" is a complicated kind of impact statement, by which a series of subcommittees and councils of the State Health Planning Council (HSHCC and SHPDA) decide whether or not the proposal is in the best interests of the area consumers.

The spirit of the law is to examine the impact of big-ticket purchases on local health costs. But to apply the letter of the law to a group of established physicians moving down the street, and spending $20,000 per head for new quarters, is ridiculous!

So here come the doctors, through round after round of hearings (called "JAR" and "SAC"), defending to the laypersons (by law 51% "consumers," which seems to mean being wholly unaware of the issues) why they need to move down the street. And patiently the physicians explained to citizens who didn't know CBC from DSS, why it is medically necessary to do a few lab tests in the office (the consumers finally agreed to permit this), and why they wanted to dispense some drugs as a convenience (they were turned down), and about X-ray machines (denied), and insurance "assignment," and RVS, and on and on into the night.

The whole business was a nightmare of "hyperdemocracy"—the sovereignty of the unqualified individual, added into a mass; the spectacle would have been funny, if it weren't so sad. These "consumers" of course, while variously hostile or somnolent, were also to be pitied. They were but the befuddled infantry, goaded by a hierarchy hidden in the bureaus.

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7% of the population may be harboring latent or dormant tuberculosis*

Are you testing for it during routine office physicals?

*Based on a national estimate of 15 million tuberculin reactors
Stead, W.W. and Bates, J., in Harrison's Principles of Medicine,
8th Edition, 1977, McGraw-Hill, p. 900.



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Adverse Reactions: Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons. Pain, pruritus and discomfort at the test site may be relieved by cold packs or by a topical glucocorticoid ointment or cream. Transient bleeding may be observed at a puncture site and is of no significance.
Reference: Diagnostic Standards and Classification of Tuberculosis. National Tuberculosis and Respiratory Disease Association, N.Y. 1969.

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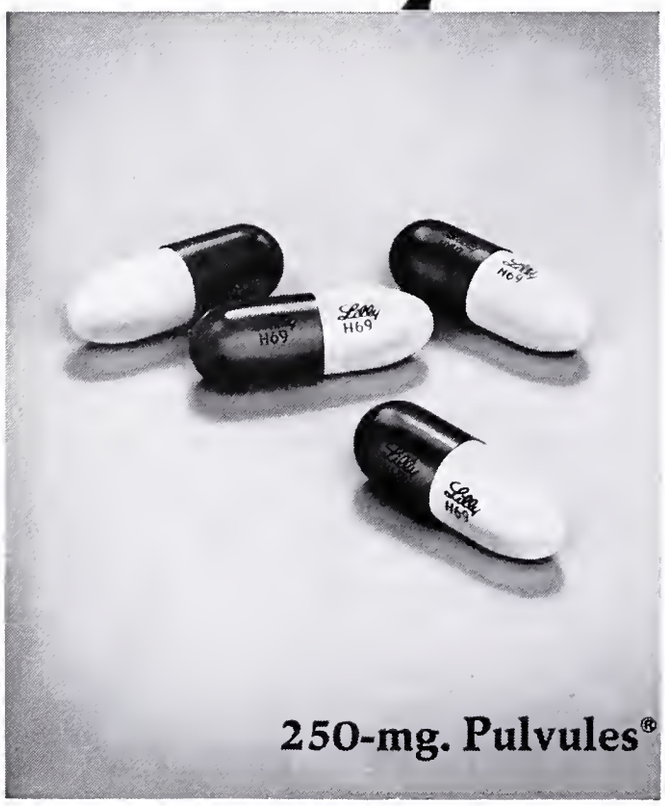
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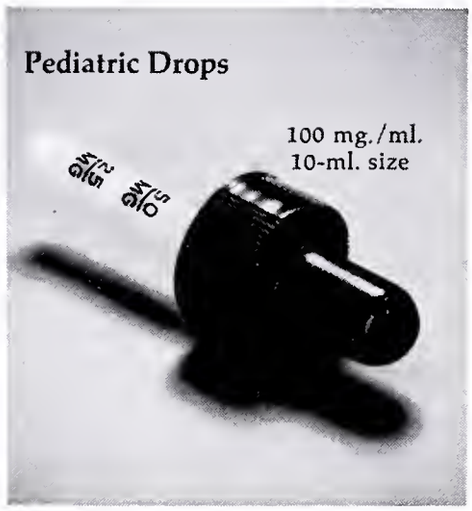
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Scoliosis Screening Pilot Project-A

Preliminary Report to Development of a Statewide School Program

JUNE FROST, B.N. (M.P.H. graduate student); HELENE SHIRATORI, R.P.N.; *and* JEREMY LAM, M.D., M.P.H., *Honolulu*

• *A scoliosis screening pilot project was conducted at Kaimuki Intermediate School in January-February of 1978 by the School Health Branch, Hawaii Department of Health, in cooperation with the Department of Education. The purpose of the pilot project was to determine the incidence of scoliosis in a sample study group and to establish a baseline to explore the feasibility of a statewide screening program in all public schools in Hawaii.*

Early detection of structural idiopathic scoliosis is essential, as spinal curves commonly occur in adolescence and may progress during this period of rapid growth. Spinal curvatures discovered early and adequately treated throughout the "growth spurt" can prevent severe deformity and costly complicated surgery.[1]

A number of states have established routine scoliosis screening in schools including Minnesota since 1973 and Delaware since the 1960s. Delaware because of its statewide school screening program which has been in operation for more than ten years, virtually has no children who now require surgical correction for idiopathic scoliosis.[2]

Method

Several meetings were held with the school administration and the head of the Physical Education Department to discuss the feasibility and implementation of a scoliosis screening project. An orientation to scoliosis was presented to the entire faculty utilizing a film, scoliosis pamphlets, an oral presentation by the School Health Branch Chief and school nurse.

Students received information about scoliosis and the method of screening through their respective P.E. teachers.

Parents were informed about the program and the method of screening one month prior to the screening dates through letters taken home by the students. They were requested to inform the school if they did not wish to have their child participate.

Initial screening was done by class periods in the P.E. shower rooms; girls on one day and boys on another. Boys were examined bare-backed while the girls wore gym shorts and tops or two-piece bathing suits.

Students were examined by viewing their posture from the front, side, back and forward bending position with arms hanging straight down from the shoulders. The school nurse checked for the following signs of scoliosis: (1) asymmetry of shoulder height, (2) asymmetry of hips, (3) unequal distances between arms and body, (4) prominence of one breast more than the other, (5) asymmetry of flanks, (6) asymmetry and prominence of scapula, (7) thoracic asymmetry (rib hump), (8) other spinal deformities, eg, lordosis and kyphosis. Students who were found with any of the above conditions were referred to the orthopedic surgeon for rescreening at a later date. Those who failed the rescreening were referred to their private physician for further evaluation and, if indicated, a standing A.P. x-ray of the spine.

In respect to follow-up, the school nurse made phone calls to families starting one month after the students were referred. In May, a form letter was mailed to parents of those students for whom

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there were no follow-up reports. Subsequently, interviews were held with each student to obtain current information as to whether they had seen a physician. For those who still had not sought medical advice, phone calls to parents were attempted again.

Results

A total of 651 students (281 girls; 370 boys) in grades 7 and 8 were screened for spinal deformity. Twelve students were not screened as they were known to be under the care of a physician. A total of 279 students were considered positive in the initial screening by the school health nurse. Of these, 196 students were rescreened by the orthopedic consultant. Of this total, 141 were questionable and are to be rescreened by the school health nurse in 6-12 months. A total of 40 students (6.1%) examined by the orthopedic consultant were referred to their own physicians. Of the 40 referrals, 31 (77.5%) were girls and 9 (22.5%) were boys.

Complete follow-up data is not available at the time of this report. However, so far 31 have been to see their physician. Previously undiagnosed scoliosis has been confirmed in 17 girls and 2 boys. One boy with scoliosis was previously known to his physician. Two girls had a confirmed diagnosis by lordosis/roundback and 6 were normal. All referrals but 3 of those considered normal had x-rays done. Three of the 31 are pending further evaluation by an orthopedic specialist.

Disposition of diagnosed cases was as follows: 19 to return for observation; one treatment completed; 2 to receive bracing; 3 of the 19 under observation have been prescribed exercises.

The degree of curvature was not noted on all follow-up forms received and parents were unable to relay this information. However, for those cases that were reported, the degree of curvature varied from less than 5 to 18 degrees for scoliosis, 54 degrees for roundback and 30 degrees for lordosis.

The data at the present time indicate a significant incidence of 3.3% of spinal deformity in the study group screened. The incidence could be higher on the completion of follow-up.

The importance of early screening for spinal defects is emphasized in the following statement released by the American orthopedic surgeons in July, 1974:

> "The American Academy of Orthopedic Surgeons hereby gives its official recommendation to any program of routine examination of school children for the detection of scoliosis and other crippling spine deformities. The Academy recognizes that by early detection more appropriate treatment can be given and a better total treatment of this disabling health problem can be carried out."[2]

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Colon Cancer Detection Using Guaiac Screening

JOHN N. WITHERS, M.D., F.A.C.S. *and* WILLIAM C. JAMES, M.D., F.A.C.P.,*
Kahului, Maui, Hawaii

• *Cancer of the colon is the leading major malignant disease that affects both men and women in this country. It is estimated that 101,000 new cases were discovered in 1977,*[1] *and 60 to 70 percent of these patients will ultimately die of their disease.*[2,3]

In Hawaii in 1976, there were 232 cases of cancer of the colon, 138 of the rectum, 156 of the stomach and 40 of the esophagus for a total of 566 cases of cancer of the G.I. tract. This compares to 303 cases of cancer of the lung and 291 of the breast.[4]

Gross bleeding, pain or obstruction occur late in cancer of the colon, and the appearance of these symptoms forewarns a poor outcome, whether the symptoms have been present for only one month or for 12 months.[3] However, when asymptomatic cancers of the colon are discovered, the 5-year cure rate is excellent at 90 percent,[5] and it is this goal toward which we should strive.

Greegor in 1966 began screening his office patients with guaiac-impregnated slides as prepared commercially by Smith, Kline & French. He reported that asymptomatic cancers of the colon could be detected which were still localized to the bowel wall.[6] His report has been followed by other screening programs,[7,8,9] which have been more or less successful for reasons which will be discussed later.

Method

Hawaiian Commercial and Sugar Company of Kahului, Maui, Hawaii, is the largest of Hawaii's sugar plantations, employing over 1100 workers. Instructional talks were held with groups of 30 to 50 H.C.&S. employees, both management and field workers, twice weekly. Small groups were chosen in order to have better doctor-patient communication. Question and answer periods proved to be very instructive for both. Only employees age 40 and over were screened; because the mandatory retirement age is 65, the age bracket we studied represents only 40 percent of the gross at risk for cancer of the colon.[10]

Any employee who had noted rectal bleeding within the previous 6 months was excluded from this study and was investigated immediately at the clinic.

The screening as recommended by Greegor consisted of 5 days of a "red-meat" free diet (chicken and cooked fish are allowed), along with increased amounts of "roughage." Instructions stressed that ASA, iron pills and vitamins were to be avoided. On the third, fourth, and fifth days, specimens were taken from 2 areas of the stool and applied to the hemoccult slides. When all 6 specimens had been obtained, the patients were told to return the slides to the clinic laboratory for testing.

If any of the 6 specimens was positive for occult blood, the following protocol was used: a barium enema (later changed to an air-contrast barium enema) and flexible fiberoptic sigmoidoscopy were performed. If these studies were negative, the next step was a fiberoptic gastroscopy, followed by a colonoscopy. These were chosen because of our high proportion of employees of Japanese descent and our concern about carcinoma of the stomach.

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*Maui Clinic, Kahului, Maui.

Results

Of the 1050 employees tested, 112 (10.6%) were found to be positive for occult blood on one or more of the 6 guaiac slides. All patients with "trace" results were considered negative after several such patients had been thoroughly investigated and no lesions found. It has been recommended by other authors that "trace" results not be investigated.[11] Investigation of the 28 "positive" patients with BE with air, short and long colonoscopy, and gastroscopy revealed the following lesions: (Table 1)

Four carcinomas of the colon, one Dukes' B, 2 Dukes' C and one small 2 cm. carcinoma not staged as the patient has declined surgery and wishes to "pray away" his cancer. Two of the 4 cancers were missed on barium enemas.

Two gastric carcinomas. One unresectable at surgery and the other resectable, but not curable.

Patients with polyps ranging in size from 3 mm. to 4 cm. numbered 25. Two-thirds of the polyps (including a 4 cm. polyp) were missed on barium enema.

A 4 cm. submucosal lipoma of the transverse colon (demonstrated on barium enema).

One gastric ulcer, unsuspected, which was benign on biopsy.

Two benign gastric polyps, which were excised through the gastroscope.

Six patients with gastritis. It was believed by the endoscopist that the gastritis in these patients was severe enough to have been the site of bleeding.

In 40 patients (42%) no abnormality was found that might have caused bleeding. These included patients with diverticulosis and hemorrhoids. This group would be considered as "false positives" by some investigators or "inadequate examination" by others. Small bowel series, aortography, or pancreatic scans could be the next steps, but we have chosen to repeat the guaiac testing with even more careful attention to the diet.

In the instructions from Smith, Kline & French, it is recommended to avoid turnips because they contain peroxidase and will give a false positive test. One of the staples of the Japanese diet in Hawaii is the *daikon* or white turnip. It is sliced or grated and eaten fresh, or pickled as *takuwan* or *sanbaizuke*. The turnip tops, pickled, are known as *tsukemono*. The high false positive rate in our first 1050 patients may be due in part to our failure to stress the importance of avoiding *daikon*.

TABLE 1.—*Results of guaiac screening and investigation.*

	NO. PATIENTS
Patients age > 40 screened	1050
One or more positive guaiac stool specimens	112
Carcinoma of colon	4
Carcinoma of stomach	2
Polyps of colon	25
Submucosal lipoma of colon	1
Gastric ulcer	1
Gastric polyp	2
Gastritis	6
No pathology evident	40

Discussion

Cancer of the colon remains our leading cancer problem, and the mortality has not been altered significantly in the last 30 years.[5,6] Unlike cancer of the lung, which probably could be eliminated by eliminating cigaret smoking, cancer of the colon at this time can only be attacked by earlier discovery. By this means, the 5-year survival rate may be increased from the present 30 to 40 percent up to 90 percent.

Many community screening programs have shown that cancer of the colon can be detected early.[7,8,9] However, these same programs have also demonstrated that a significant obstacle to early cancer detection is poor follow-up of positive guaiacs by primary care physicians. Of patients found to have positive guaiac tests, 50% never received a barium enema or a sigmoidoscopy. If a screening program is to be successful, the primary care physician must follow through with the necessary x-rays and examinations.

This leads to the next logical question: "What are the necessary x-rays and examinations?" Are the barium enema and sigmoidoscopic exams sufficient? The routine barium enema has been found to be inaccurate when looking for the small carcinomas or polyps under 1 cm. in size.[12,13] Therefore, we recommend an air-contrast barium enema. The rigid sigmoidoscope, the mainstay of the physician for generations, has its failings in evaluating the sigmoid colon, with the average exam visualizing only 18 to 20 cm. and 25 cm. being reached in only 30 percent of the cases.[14,15] Also, it has been pointed out that, contrary to earlier teachings, the majority of sigmoid polyps and carcinomas are in the proximal sigmoid colon, beyond the reach of the rigid sigmoidoscope.[16]

Colonoscopy of the entire colon is the ideal approach, but the cost and the number of colonoscopists required to follow up the large number of patients with positive guaiacs after a community screening program makes this approach impractical at the present time. The answer to the complete examination of the sigmoid colon appears to be the recently developed 60-cm. "short colonoscope" or the flexible fiberoptic sigmoidoscope. With this instrument, the junction of the descending colon and sigmoid colon can be reached in 75 percent of cases and the splenic flexure in 30 percent.[15] The technique can be learned in a short time, and the procedure is suitable for office use by the primary care physician who is interested in colorectal diseases.

One significant problem discovered by this screening program was the high incidence of false positive tests (42%). This causes needless worry and discomfort to the patient, plus extra costs to insurance plans. In our next screening project—the senior citizen groups of Maui—we will recheck each patient having a positive hemoccult test with another 5-day/6-slide hemoccult test. Those who are negative on the second test will be retested at one month to be sure that they remain negative.

Summary

Guaiac screening offers the opportunity for early detection of carcinoma of the colon. An ongoing screening program of agricultural employees is presented, with the discovery thus far of 4 patients with carcinoma of the colon, 2 patients with carcinoma of the stomach and 25 patients with colon polyps.

Complete follow-up of a patient with a positive guaiac test should include an air contrast barium enema and an examination with either a flexible fiberoptic sigmoidoscope or a colonoscope.

The potential saving of lives warrants the full cooperation of the medical community in the attack on cancer of the colon.

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Notice to Hawaii Physicians: Travelers Insurance Company has become the administrator for the health insurance program of the Western Electric Company, beginning late 1978, and wishes to notify all Hawaii physicians that the Travelers has established a single, nationwide claims center for the Western Electric program, in Greensboro, North Carolina. The employee or dependent under this program submits claims directly to this office and is furnished a claims form for that purpose. It is not necessary that the Physician Report that is supplied by Western Electric be used, but any form will be accepted that supplies the full information: patient name, diagnosis, charges, and dates of service.

DSSH wishes to make available to Hawaii physicians, the following policy on second medical opinions for elective surgery:

In a recent communication from the Dept. of Health, Education and Welfare, it was indicated that second medical opinions were recommended to certain elective surgical procedures. It has been determined that experience on the mainland has not been observed in Hawaii regarding the most frequent surgical procedures being performed. In certain cases, patients may desire a second opinion and such requests have been honored in the past. While, in general, it is not considered necessary that a second opinion be obtained, the Department will nevertheless honor such requests when there is a reasonable doubt on the part of the patient that such recommended procedure is necessary.

Twenty-five Percent of operating expenses of hospitals in New York state were for compliance with government regulation, according to a Hospital Association of N. Y. State study.

The Aerospace Medical Association has commissioned a comprehensive volume dealing with the role of medicine and its allied sciences in the success of manned flight—from early balloon ascents to extra-terrestrial space travel. Written by Arnold Lott and Eloise Engle, it is entitled "MAN IN FLIGHT: Biomedical Achievements in Aerospace," and is scheduled for publication in May 1979, to coincide with the 50th Anniversary of the Aerospace Medical Association.

A brochure containing more information and a pre-publication discount offer can be obtained by writing to or calling the Aerospace Medical Association, Washington National Airport, Washington, D.C. 20001. (703) 892-2240.

The Alpha of Hawaii Chapter of the Alpha Omega Alpha at the John A. Burns School of Medicine, University of Hawaii is interested in locating all Alpha Omega Alpha members residing in the State of Hawaii. We request all Alpha Omega Alpha members who have not already had communication with the Alpha Chapter to please forward your name and address to Clifford J. Straehley, M.D., President Pro Tem, 1697 Ala Moana Blvd, Honolulu, Hawaii 96815.

Federal Health Planners now considering the use of "productivity standards" to judge the efficiency of medical care by physicians and hospitals, says HEW Secretary J. Califano. Califano feels such standards might reduce unnecessary surgery, better employ medical devices, and shorten hospital stays.

The First HMO Funded by the Government to demonstrate alternatives to the health care system is going out of business. Sound Health Association of Tacoma, Washington, started by the federal government five years ago at a cost of $300,000 and supported by a $2.5 million federal loan, has losses now of about $40,000 a month and has failed to reach a break-even point within a 36-month deadline. Group Health Cooperative of Puget Sound, a 31-year-old HMO based in Seattle, said it has offered to buy Sound Health's major assets.

Disciplinary Action Against Physicians increased six-fold between 1971 and 1977 according to an AMA survey of state medical disciplinary boards. In 1971, 119 actions revoked licenses, suspended narcotics permits, censured physicians, or denied license reciprocity. In 1977, there were 685 such actions.

Newest Medical Society is the California House Officer Medical Society. The organization will draw its membership from interns, residents, and fellows in training in the State and provide a transition to local medical society affiliation.

The AMA's Uniform Health insurance claim form, introduced in 1974, is becoming the predominant uniform claim form throughout the health insurance industry. The AMA form was designed for use with both the private health insurance industry and with government programs. The Health Insurance Association of America states that each of its approximately 300 member companies will accept the form for processing when submitted by a physician's office. The Blue Shield Association says 24% of their 70 member plans have adopted the AMA form as their primary claim document, while the remaining plans, **with the exception of 12,** will accept it for processing.

A study now underway in HCFA(HEW) to determine the feasibility of using the AMA form as the common claim document for Medicare and Medicaid programs. Medicare carriers in 11 states now using AMA claim form and carriers in 3 other states now waiting approval from Medicare Bureau.

Kailua Medical Arts Building has limited space, from 392 to 1800 square feet, available on realistic terms. This should be of interest to dentists, or to physicians specializing in allergy, cardiovascular diseases, family practice, industrial medicine, ophthalmology, orthopedics, otolaryngology, pathology or thoracic surgery. Established laboratory, X-Ray and pharmacy support facilities and the adjoining City-County parking lot make the building an excellent opportunity to establish a primary or satellite M.D. office. Leasing is being handled by Ray Underwood, 531-1302 or 373-2458.

CME OFFERINGS

1. Mar. 9 - 11, 1979, San Diego, California; **Gastrointestinal Radiology, Update '79;** offered by San Diego Radiology Research and Education Foundation and the American College of Radiology. The course subject matter will include all aspects of gastrointestinal radiology, with upgrade on latest techniques, as well as a general intensive review. Fee for program is $200 and grants 18 hours of AMA Category I credit. Registration and information, contact Mary J. Ryals, Radiology, P. O. Box 2305, La Jolla, CA 92038; (714) 453-7500, ex. 3711.

2. Feb. 7 - 9, 1979, San Diego, California; **Selected Topics in Neuroradiology;** offered by San Diego Radiology Research and Education Foundation and American College of Radiology. The course subject matter will be an in-depth discussion of selected topics in head and neck radiology with emphasis on ENT, the orbits and the spine. Fee for program is $225 with 22½ hours of AMA Category 1 credit granted. Registration and information, contact Mary J. Ryals, Radiology, P. O. Box 2305, La Jolla, CA 92308; (714) 453-7500, ex. 3711.

3. Jan. 26 - 27, 1979, Houston, Texas; **Radiology of the Acutely Ill and Injured Patient;** offered by Univ. of Texas Medical School at Houston, Dept. of Radiology. Fee of $150. Course meets criteria for 14 credit hours AMA Category 1; 14 ACEP Category I credits; 14 Prescribed Hours of AAFP. Contact Division of Continuing Education, Univ. of Texas Health Science Center at Houston, P. O. Box 20367, Houston, Texas 77025; (713) 792-4671.

4. Apr. 27 - May 1, 1979, New Orleans LA.; **Management of Common Problems in Office Practice—Update;** sponsored by New Orleans Graduate Medical Assembly. Interested physicians contact Ms. Lois Neary, Exec. Dir., New Orleans Graduate Medical Assembly, 1430 Tulane Ave., New Orleans, LA. 70112.

5. Feb. 5 - 9, 1979, Captiva Island, Florida; **Management of Respiratory and Cardiac Failure,** sponsored by Amer. College of Chest Physicians. Fees—CCP members, $185, nonmembers, $200, residents, nurses, therapists, $160. Course will emphasize the management of respiratory and cardiac failure, will stress pulmonary and cardiac function in health and disease as well as the assessment of the patient with respiratory and cardiac insufficiency, will discuss pathophysiologic disturbances present in COPD, asthma, ARDS, and pulmonary hypertension. Approved for 22½ AMA Category 1 credit hours. Contact Dale E. Braddy, Dir. of Education, Amer. College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068.

6. Mar. 22 - 24, 1979, Orlando, Florida; **International Conference on Tuberculosis;** sponsored by Amer. College of Chest Physicians and the Pittsfield Anti-Tuberculosis Assn. Program will utilize innovative problem-solving technique involving registrants and faculty; will feature internationally known experts to lecture on epidemiology, diagnosis, treatment, drug interaction, compliance, skin testing, x-ray, drug reactions, bacteriology, antituberculosis medication and hospital control. Fees—ACCP members, $160, non-member physicians, $175, residents, nurses, therapists, $125. Program Approved for 15 AMA Category 1 credit hours. Contact Dale E. Braddy, Dir. of Education, Amer. College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068.

Newly Completed Office in Aiea Medical Building for sublease. Approximately 400 sq. ft. Suitable for physician starting adult medical practice. Includes office, exam room, and sharing reception/business area. Interested physicians call 734-8161 after 7 p.m.



Editorials

Valedictory

For several weeks in the past couple of months, Castle Memorial Hospital has been overflowing with in-patients. Seriously ill people have had to be exposed to passersby as they lie partially screened behind makeshift blinds in the busy hallways, suffering the lack of amenities usually accorded the more fortunate ones in decent private rooms. Of course they survive—mostly.

At the same time other in-patients have had to have their normal hospital days cut short, at some risk to their convalescence, just to allow the "more sick" to have a bed. Some have had to remain a day or so longer in the expensive CCU or ICU for lack of acute care beds elsewhere in the hospital.

As for moving the convalescents upstairs to SNF—the Skilled Nursing Facility—which is a lower level of care, let us all guffaw! The Feds have seen to it that the private sector gets no incentive to build or maintain these or the even lower levels of Nursing and Care Homes. A review of the figures at Castle for the months of August, September and October shows that 33 acute care in-patients, ready for transfer, waited a total of 359 days to go "upstairs."

And yet, the "guidelines" promulgated by DHEW state that we have too many hospital beds in Hawaii. The specific recommendation for Castle is to reduce its complement of beds by ten!

If the figures are available, a similar situation can undoubtedly be found at QMC, St. Francis and Kuakini hospitals. As we have so often expounded: The essence of PL 93-641 is cost-containment by means of denial of benefits to the people.

Certificate of Need (CON) is another mechanism that uses similar tactics of a nefarious nature.

Castle Hospital has had a successful experience with its "human services" unit of ten beds, which is actually an acute care facility for psychiatric cases. As a result of the State Hospital's retrenchment as an in-patient institution particularly affecting the Windward side, Castle Hospital has helped fill the void in services. The only other portal of entry for the psychiatrically acute emergency on O'ahu has been QMC, but it is not only "over-the-hill" for Windwardites but also full to overflowing usually.

So Castle, fortunately with loft space available, has applied for a CON to expand this unit to 20 beds through an internal shift that will actually release 10 beds to acute Med/Surg. In order to accomplish this so-obviously needed expansion, a large, fat and detailed compendium had to be put together and then presented to the State bureaucracy. It is still "moving up the line." This takes time—time is money in these days of rapid inflation. The document cost about $40,000 to prepare, which translates to an additional $2,000 per bed projected.

Cost containment? Federal regulations are **The** prime factor in the escalation of health care costs.

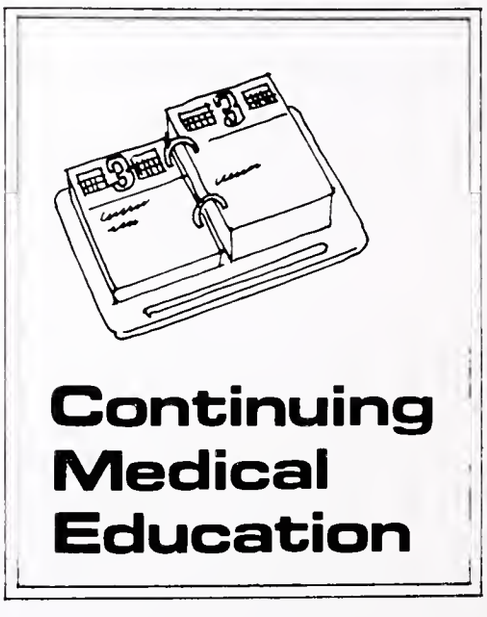
J.I.F.R.

Aloha

With the above editorial, one of many on the same subject (probably *ad nauseam* to many of the Journal's readers) speaking out against overwhelming Federal and State bureaucracies, we shall call it quits!

After 15 years of almost steady bi-monthly and then monthly polemics and diatribes, and upon reaching the age when ye editor can qualify for "free" Medicare and a pass on TheBus, it is high time that the younger members of a beloved profession pick up the pen (or peckmachine), take over, and try as continuously to butt their heads against THE stonewall. Aloha to you all.

J.I.F.R.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

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Proceedings of
The House of Delegates



122nd Annual Meeting
October 1-6, 1978

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HAWAII MEDICAL ASSOCIATION—Committee Structure for 1978

HMA Council

Marion L. Hanlon, President
George Goto, President-Elect
Calvin C. J. Sia, Past President
Douglas B. Bell II, Secretary
William H. Hindle, Treasurer
William E. Iaconetti, Alternate AMA Delegate
Herbert Y. H. Chinn, AMA Delegate

Bylaws & Parliamentary

Sigdian S. Lim, Chairman
Douglas B. Bell II, Commissioner
Harry L. Arnold Jr.
William W. L. Dang

Act 219, Ad Hoc Committee

E. Lee Simmons, Chairman
Albert Chun-Hoon
William W. L. Dang
Robert DiMauro
Richard Fardal
George Goto
Leonard Howard
Bruce Joseph
Roy Kuboyama
Chew Mung Lum
Helen Percy (Maui)
J. I. F. Reppun
Theodore Tseu

Commissions

Cancer, Grover H. Batten
Health Service and Care, Donald Char
Internal Affairs, Douglas B. Bell II
Interprofessional & Public Affairs, Philip McNamee
Legislation, George Goto
Medical Education, Nadine Bruce
Medical Services, William Dang
Peer Review, Ann B. Catts
Public Health, Roy Kuboyama

Councilors

John Edwards, Jr. (1978)
Calvin C. M. Lum (1978)
Rowlin Lichter (1978)
Arnold Siemsen (1978)
Leonard Howard (1979)
Felix J. Lafferty (1979)
Alexander Roth (1979)
Neal E. Winn (1979)
Denis J. Fu (Maui) (1979)
Arch Wigle (Hawaii) (1979)
Peter Kim (Kauai) (1978)

County Presidents

Patrick J. Walsh, Honolulu
Russell Stodd, Maui
James Williams, Hawaii
Rex Couch, Kauai

Arrangements

Douglas B. Bell II, Chairman and Commissioner
William W. L. Dang
William Davis
William Iaconetti
Worldster Lee
Dennis Maehara
Andrew Morgan
R. Varian Sloan
Herbert Uemura
Henry Yokoyama
Franklin Young

Building

Marion Hanlon, Chairman
Douglas B. Bell II
George Goto
William Hindle
Calvin C. J. Sia
Patrick Walsh
Thatcher Magoun (Kauai)
Russell Stodd (Maui)
James Williams (Hawaii)

Cancer

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Roy Kuboyama, Commissioner
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Carl Boyer Jr.
Ann B. Catts
Paul Condit
Paul DeMare
Fred Gilbert
Norman Goldstein
Reginald Ho
Azucena Ignacio
Robert Jim
Elmer Johnson
John H. C. Kim
Thomas Lau
Kevin Loh
James Lumeng
William Morioka
Noboru Oishi
Young Paik
Kleona Rigney
Millard Seto
Calvin C. J. Sia
Quintin Uy
Verne Waite
F. B. Warshauer
Robert Wilkinson
Drake Will
Clifford Moran (Maui)

Bureau of Research and Planning

Calvin C. J. Sia (1980) Chairman
Herbert Y. H. Chinn (1978)
William W. L. Dang (1980)
Fred I. Gilbert (1979)
Winfred Y. Lee (1978)
John J. Lowrey (1978)
George H. Mills (1979)
Richard Omura (1980)
Henry Oyama (1979)
Theodore T. Tomita (1978)
Livingston M. F. Wong (1979)
Rex Couch (1980) (Kauai)
William Iaconetti (1980) (Maui)
Tadao Nagashima (1980) (Hawaii)

Cancer Commission

Grover Batten (1977) (HMA) Chairman
Carl Boyer Jr. (1979) (Cancer Society)
Elmer Johnson (1978) (Cancer Society)
Kevin Loh (1978) (University of Hawaii)
Noboru Oishi (1977) (University of Hawaii)
Kirsten Vennesland (1979) (Dept. of Health)
Verne Waite (1978) (Department of Health)
Drake Will (1979) (Hawaii Medical Association)

Child Health Planning, Ad Hoc Committee

Calvin C. J. Sia, Chairman
Fernando Atienza
Sharon Bintliff
Donald Char
James Drorbaugh
Sherrel Hammar
Robert Latta
Roy Niimi
Al Oglesby
Betty Soo
Henry Yim

Chronic Illness

Gladys Fryer, Chairman
Roy Kuboyama, Commissioner
Charlotte Florine
Martha L. Hefley
Kleona Rigney
Adela Sandidad
Walter Watt
DeWitt Smith (Hawaii)

Community Health Care

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Claude Caver
Stanley Chung
Robert Clingan
Michael Dimitrion
Richard Fardal
Gladys Fryer
Mary Glover
Philip Hellreich
Sigdian Lim
Eugene Magnier
Paul McCallin
George Mills
Robert Nordyke
Noboru Oishi
Alfred Scottolini
George Shimomura
Bliss Shrapnel
Katok Chuang (Kauai)
J. Mark Sowers (Maui)
Arch Wigle (Hawaii)

Disaster

Martha Lou Hefley, Chairman
Donald Char, Commissioner
Joseline Brestle
Walter W. Y. Chang
Collin Dang
Leonard Howard
David Huntley
Robert Lindberg
James Navin
Deborah Putnam
James Matayoshi (Hawaii)
Andrew Sackett (Hawaii)

Communicable Disease

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Roy Kuboyama, Commissioner
Samuel Allison
Steven Berman
Donald Char
Richard Dang
Amelia Jacang
Lawrence Lau, Jr.
James Lumeng
John Peyton
Betty Soo
Kirsten Vennesland
Katok Chuang (Kauai)
William Kepler (Maui)
Donna McCleary (Maui)

Crippled Children

D. V. Reddy, Chairman
Roy Kuboyama, Commissioner
Sharon Bintliff
Yujen Hsia
David Kimura
Katsuji Kubo
Jordan Popper
Pauline Stitt
Thomas Walinski
Michael Weiner
Katok Chuang (Kauai)
Denis Fu (Maui)
William Kepler (Maui)

Economic Evaluation & Adjustment

Marion Hanlon, Chairman
William Dang, Commissioner
George Goto
Chew Mung Lum
James Mertz
Rodman Miller
John Morris
Henry Yokoyama
Walter K. W. Young
Patrick Cockett (Kauai)
William Iaconetti (Maui)

Emerging Medical, Moral and Legal Concerns

Arnold Siemsen, Chairman
Ann B. Catts
Gladys Fryer
Mary Glover
John J. Lowrey
Herbert Nakata
Jordan Popper
J. K. Sims
Raymond Taniguchi

Fee Survey

Maurice W. Nicholson, Chairman
William W. L. Dang, Commissioner
Edward Chesne
John Corboy
William Davis
Raymond DeHay
George Ewing
Allan Izumi
Calvin Kam
David Kimura
Rowlin Lichter
Carl Lum
L. Q. Pang
Werner Schroffner
E. Lee Simmons
Thomas Teruya
Hamilton Winston
Walter Young

Health Manpower/Health Care Costs

Claude V. Caver, Chairman
Donald Char, Commissioner
Norberto Baysa
Thomas Cahill
Albert Chun-Hoon
George Goto
Leonard Howard
Thomas Ito
Elmer Johnson
Michael McCabe
George Mills
Robert Nordyke
Alfred Scottolini
Bliss Shrapnel
Benjamin Tom
Hamilton Winston
J. B. Mark Sowers (Maui)

Emergency Medical Services

Livingston Wong, Chairman
David Eith
Douglas Ostman
Stanley Saiki
Mr. Henry Thompson
(Department of Health)
Mr. Paul Cook (Hospital Association)
William Dang, ex-officio, non-voting
Mr. Jon Won, ex-officio, non-voting

Finance

William Hindle, Chairman
Marcelino Avecilla
Grover Batten
Albert Chun-Hoon
William W. L. Dang
Elmer Johnson
Andrew Morgan
Richard Omura
Andrew Don (Maui)
Moon Park (Hawaii)
Mark Wentworth (Kauai)

Legislation

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George Goto, Commissioner
Clarence Chang
Robert Clingan
Richard Dang
William Dang
James Doyle
Richard Fardal
Robert Faus
William Hindle
David Kimura
Roy Kuboyama
Eugene Magnier
Maurice Nicholson
Noboru Oishi
George Schnack
E. Lee Simmons
Theodore Tseu
Herbert Uemura
Sau Ki Wong
Herbert Young
Ernest Bade (Hawaii)
Helen Percy (Maui)
Kazuhisa Abe, Atty.
Mrs. Priscilla Chung
Mrs. Miriam Hellreich
Mrs. Carol McNamee
Mrs. Alice Tucker

Maternal & Perinatal Mortality Study

George Goto, Chairman
Ann B. Catts, Commissioner
Robert Allin
Mario Bautista
Ronald Berman
Rodney Boychuk
Thomas Burch
Co. Samuel Chaney
Robert DiMauro
James Drorbaugh
David Easa
Donald Fox
Gary Fujimoto
Kenneth Grant
Clayton Honbo
Leonard Howard
Gordon Ing
Roy Kaye
Fook Chiu Li
Gail Li
Steven Golde
Paul McCallin
Wayne McKinny
Richard Mitsunaga
Carl Morton
Herbert Nakata
Shigeo Natori
Roy Niimi
John Ohtani
Gordon Ontai
Thomas Oshiro
Maj. Gary Pettett
Kathleen Poon
Richard Sakimoto
Norman Sato
Walton Shim
George Shimomura
John Spangler
Wayne Takemoto
Francis Terada
Thomas Teruya
Elbert Tomai
Theodore Tseu
Herbert Uemura
Jim Wilson
James Wong
Keijiro Yazawa
Franklin Young
Joseph Young
Lockwood Young
Patrick Aiu (Kauai)
Denis Fu (Maui)
William Patterson (Maui)
Wolfgang Pfaeltzer (Maui)
D. Venu Reddy

Medical Education

Nadine Bruce, Chairman
and Commissioner
Harry Arnold, Jr.
Norberto Baysa
Ralph Beddow
William Boyson
Ann B. Catts
Benjamin Chang
Albert Chun-Hoon
Fortunato Elizaga
Sherrel Hammar
William Hindle

Edgar Ho
Pill Hong
Azucena Ignacio
Gordon Ing
Charles Judd, Jr.
Roy Kamada
Roy Kuboyama
Ivar Larsen
James Lumeng
Bal Raj Mehta
Noboru Oishi
James Orbison
James Phillips
Lynn Rayner
Jose Romero
Pauline Stitt
Ramon Sy
Benjamin Tom
Verne Waite
Patrick Walsh
Thomas Whelan
Manas Ghosh (Hawaii)
Clifford Moran (Maui)
J. Mark Sowers (Maui)
Sakae Uehara (Maui)

Medicaid, Ad Hoc Committee

Roy Kuboyama, Chairman
George Bolian
Walter W. Y. Chang
William Dang
John Keenan
Eugene Magnier
Ruben Mallari
Wayne McKinny
Noboru Oishi
Alexander Roth
Marc Shlachter
Calvin C. J. Sia
Verne Waite
Hamilton Winston

Peer Review

Chew Mung Lum, Chairman
Ann B. Catts, Commissioner
Murray Berger
Frank Ceccarelli
William Dang
Takakazu Fukumura
Victor Hay-Roe
Malcolm Ing
Bal Raj Mehta
James Penoff
Ernest Bade (Hawaii)

Public Affairs

Philip McNamee, Chairman
and Commissioner
Claude Caver
Robert Clingan
Michael Dimitrion
Charlotte Florine
Gerald Hiatt
Virgil Jobe
George Kenessey
Robert May
Michael McCabe
George Monlux
James Penoff
Margaret Rose
George Schnack
Myron Shirasu
Theodore Tseu
Patrick Walsh
Henry Yokoyama
William MacDonald (Maui)

Nominating

Herbert Chinn
William Dang
Andrew Morgan
Calvin Sia
Patrick Walsh
Peter Kim (Kauai)
Richard Lundborg (Hawaii)
Sakae Uehara (Maui)

Professional Liability

Bernard Fong, Chairman
Ann B. Catts, Commissioner
Duane Beringer
Clifford Chock
John Edwards
Raymond Fujikami
George Goto
David Kimura
Gail Li
Chew Mung Lum
Gabriel Ma
Mor McCarthy
Robert Thune
John Watson
George Bracher (Hawaii)
Peter Kim (Kauai)
John Withers (Maui)

Public Safety

Truett Bennett, Chairman
Roy Kuboyama, Commissioner
Edwin Dierdorff
Michael Dimitrion
Michael McCabe
John Spangler

Publications

William Moore, Chairman
Douglas Bell H, Commissioner
Harry Arnold, Jr.
Charlotte Florine
Pill-Whoon Hong
Doris Jasinski
James Lumeng
Young Paik
J. I. Fred Reppun
Alfred Scottolini
Henry Yokoyama

School Health

Ann B. H. Yee, Chairman
Roy Kuboyama, Commissioner
Donald Char
L. T. Chun
Michael Hase
Amelia Jacang
John Peyton
Adela Sanidad
Betty Soo
Pauline Stitt
Kirsten Vennesland
Thomas Walinski
Katok Chuang (Kauai)
Denis Fu (Maui)
William Kepler (Maui)
Donna McCleary (Maui)

Self-Insurance, Ad Hoc

Maurice Nicholson, Chairman
Herbert Chinn
Albert Chun-Hoon
William Dang
John Edwards
George Ewing
Bernard Fong
George Goto
Marion Hanlon
Elmer Johnson
Roy Kuboyama
Gail Li
Gabriel Ma
L. Q. Pang
Alexander Roth
Calvin Sia
Sakae Uehara (Maui)

Substance Abuse/Pharmacy

James Lumeng, Chairman
Roy Kuboyama, Commissioner
Donald Char
Bernice Coleman
Edwin Curphey
Gladys Fryer
Russell Hicks
George Kenessey
Lawrence Lau
William Kepler (Maui)
Helen Percy (Maui)

Scientific Program

Herbert Uemura, Chairman
Douglas Bell H, Commissioner
William Boyson
Nadine Bruce
Richard Frankel
Norman Goldstein
Ralph Hale
John Kim
Douglas Massey
Irwin Schatz
Kazuo Teruya
Thomas Whelan
Robert Wiebe

Sports Medicine

Edward Kagihara, Chairman
Roy Kuboyama
James Bennett
Noni Brar Koch
Robert May
Bal Raj Mehta
Thomas Richert
Patrick Walsh
Walter Loo (Hawaii)
Pete Okumoto (Hawaii)

Task Force on County/State Relationships

Ann B. Catts, Chairman
Members to be appointed

Tel-Med Joint Executive

Philip McNamee, Commissioner
Gerald Hiatt
Rowlin Lichter
Bob Nichols (HMSA)
Lynda Miyamoto (HMSA)

TV-Radio

Henry Yokoyama, Chairman
Philip McNamee, Commissioner
Samuel Allison
John Corboy
Virgil Jobe
John Keenan
Sigdian Lim
George Monlux, Jr.
William Myers
Noboru Oishi
Ronald Pion
E. Lee Simmons
Michael Weiner
Helen Percy (Maui)
Russell Stodd (Maui)
Phillip McNamee

Worker's Compensation

Bernard Scherman, Chairman
William Dang, Commissioner
Francis T. C. Au
Patrick Donley
Raymond Dusendschon
William Iaconetti
David Kimura
Ben Leung
Herbert Luke
Maurice Nicholson
L. Q. Pang
R. Reginald Patterson
Robert Simmons
James Phillips (Hawaii)
Edward Underwood (Maui)

PROCEEDINGS OF THE HOUSE OF DELEGATES

122nd Annual Meeting of the Hawaii Medical Association

The first session of the House of Delegates meeting was called to order by President Marion Hanlon on Tuesday, October 3, 1978 at 1:30 p.m. in the Bora Bora Room of the Ilikai Hotel. Dr. Douglas B. Bell II, Secretary, called the roll. Present were Drs. Marion Hanlon, Calvin Sia, Douglas B. Bell II, William Hindle, Patrick Walsh, Russell Stodd, John Edwards, Calvin Kam, Leonard Howard, Felix Lafferty, Alexander Roth, Neal Winn, Denis Fu, Arch Wigle, Peter Kim, Herbert Chinn, William Iaconetti, William Dang, Harry Arnold, George Mills. Delegates from county societies included: Honolulu—E. Lee Simmons, Vincent Aoki, Ralph Beddow, Carl Boyer, Danelo Canete, Ann Catts, Jeanette Chang, Walter Chang, Herbert Uemura, Henry Fong, Bernard Fong, Roy Kuboyama, Wayne McKinny, Andrew Morgan, Victor Mori, Ronald Peroff; Maui—Gary Salenger, Helen Percy; Kauai—Burt Wade; Hawaii—Ernest Bade.

AMA President Tom Nesbitt was asked to address the House of Delegates. He spoke on the role of the AMA in the Voluntary Effort.

Dr. William Dang was appointed to serve as parliamentarian for the meeting. Drs. Burt Wade and Victor Mori were appointed sergeants at arms.

The minutes of the 121st Annual Meeting as published in the December 1977 issue of the HAWAII MEDICAL JOURNAL were approved.

The reports of the President, Secretary, Treasurer and component societies (except Kauai) were included in the delegates handbook and referred as indicated. The resolutions were also assigned to reference committees.

Reference committees were appointed as follows: Miscellaneous Business—Neal Winn (Chairman), Helen Percy, John Edwards, Ralph Beddow; Public Health—Denis Fu (Chairman), Carl Boyer, Vincent Aoki, Jeanette Chang; Finance Committee—Ann B. Catts (Chairman), Alexander Roth, Ernest Bade and Andrew Morgan.

The reference committees were in session October 3 beginning at 2:30 p.m.

The second session of the House of Delegates was called to order on Thursday, October 5, 1978 at 1:30 p.m. Delegates seated on Thursday were Ruben Casile (Hawaii) and Bernard Fong (Honolulu). Delegates Beddow, Canete, Chang and Mori were absent the second session.

Mr. Jim Drake from the American Medical Association Washington D.C. office was invited to address the House of Delegates. Mr. Drake spoke on medical legislation that AMA lobbyists are currently testifying on at the federal level and the outlook for medical legislation during 1979.

Reference Committee On Miscellaneous Business

Peer Review Commission

ACTION: Approved as amended.

The committees under this Commission are: The Maternal and Perinatal Mortality Study Committee, which investigates all maternal and selected fetal deaths; the Professional Liability Committee, which is responsible for determining physician insurability; and the Peer Review Committee, which acts as an appeal/review committee for county society peer review committees and as an informational source for such committees.

The Maternal and Perinatal Mortality Study Committee met regularly to investigate and review maternal death cases and perinatal cases referred to it by its Steering Committee. The main committee met regularly and reviewed 2 maternal and 19 perinatal cases this past year.

The Professional Liability Committee did not meet because of a significant reduction in its work load since the establishment of the State's medical liability hearings panels.

The Peer Review Committee did not meet during the past year.

Recommendations:

(1) That physicians doing obstetrics and/or pediatrics volunteer to serve on this committee. (Category I credits for the Physicians Recognition Award are given for attending the meetings of this committee.)
(2) That the functions of the Professional Liability Committee be reviewed during the forthcoming year and the need for its continuation be assessed.
(3) That non-HMA members be assessed an appropriate fee for services requested and rendered by the Professional Liability Committee. This fee should not be less than $100 or more than $500.

ANN B. CATTS, M.D.

Hawaii Medical Journal

ACTION: Approved as amended.

During a year when many state medical journals were experiencing financial difficulties, it is indeed a pleasure to report that the HAWAII MEDICAL JOURNAL successfully completed another year without straining the operating budget.

Much of this success is due to the professional and businesslike manner in which the Journal operates. The entire staff associated with the Journal should be commended on their performance: Editor, Harry Arnold, Jr.; Assistant Editor, Doris Jasinski; Associate Editor, Fred Reppun; News Editor, Henry Yokoyama; contributors Francis Fukunaga and Jon Won; and for handling the details of production, controlling costs, and collecting revenues, Jan Martin and Paul Steward.

It was determined that the optimum formula for the Journal should be 60% editorial and 40% advertising. During the year, we managed a ratio of 36% advertising and 64% editorial. While we fell short of the stated goal, we were none the less able to keep our heads above water financially and at the same time work off the backlog of scientific articles we had a year ago.

The membership can assist the Journal by reminding the detail men when they call on them about the Journal and our need for additional advertising.

Recommendations:

(1) That we continue to publish the HAWAII MEDICAL JOURNAL on the same basis during 1979.
(2) Approval was received from the House of Delegates to increase the advertising rates in 1978. We did not use this authority since the Journal continued to perform well. However, the Publications Committee would again like the authority to increase the advertising rates should the need arise.

HARRY L. ARNOLD, JR., M.D.

Commission on Internal Affairs

ACTION: Approved as amended.

The Commission on Internal Affairs consists of four committees: Arrangements, Bylaws, Publications, and Scientific Program. The Bylaws Committee did not meet in 1978. The reports of the other committees are printed below:

DOUGLAS B. BELL II, M.D.

Arrangements

This committee met several times during the year to arrange the 122nd annual HMA meeting at the Ilikai Hotel, again held in conjunction with the AMA Regional CME meeting. HMA was responsible for the daily State of the Art lectures; tournaments in golf, ping-pong, tennis, and skin diving; the House of Delegates meeting; exhibits, banquet; and on-site registration. The AMA with help from the HMA Scientific Program Committee was responsible for the daily CME courses. The Scientific Program Committee organized the State of the Art lectures. The HMA again hosted the popular cocktail party to welcome the visiting registrants and guests on Monday evening at the Ilikai.

The meeting lasted six days, beginning with an all day medical economics seminar, "Enhancing Your Financial Skills," on Sunday and this was partially subsidized by the Bureau of Medical Economics. The CME courses lasted several hours every morning Monday through Friday and there was a daily State of the Art lecture. The House of Delegates met on Tuesday and Thursday afternoons. The Sportsmen's Night Party to award the prizes for the various sports tournaments was held at Mid Pacific Country Club on Wednesday evening and the annual banquet climaxed the meeting on Friday evening.

Registration for the meeting which included the CME programs was $25.00 for all AMA physicians with the fee waived for HMA members and house staff physicians. Non-HMA members were charged an additional $15.00 registration fee. The CME course tuitions were separate and paid to the AMA.

Work has begun on the 1979 annual meeting, which is planned for October again, but the location has not been selected. The AMA has expressed interest in continuing the CME program here and so the HMA Scientific Program Committee has held preliminary meetings for this.

Recommendations:

(1) That the HMA plan on having another joint meeting with the AMA in 1979.
(2) That the Arrangements Committee be allowed to continue planning and make arrangements for the 1979 annual meeting with final approval by the council.

DOUGLAS B. BELL II, M.D.

Scientific Program

1978 PROGRAM

As agreed to by the House of Delegates at the 1977 annual meeting, your committee has worked with the AMA Council on Continuing Physician Education in the sponsorship of a continued HMA-AMA Regional Program for Oct. 1-6, 1978.

The first joint effort at a combined AMA Regional/HMA Annual Meeting was held last year with some degree of success but also with some problems:

(1) Increasing complaints by the exhibitors regarding diminishing attendance at the exhibits.
(2) Complaints from members unable to attend certain functions because of scheduling conflicts.
(3) Confusion of workshop and registration procedures because of the two organizations involved (HMA/AMA).
(4) Decreasing physicians attendance.

With the experience gained from last year's program, your committee decided that a reduction in scope of the workshops was in order. Several alternatives were considered; however, it has become increasingly clear that the business aspect of providing for compulsory continuing medical education was not as lucrative as was first thought several years back. It appears that this is especially true in Hawaii where so many of the hospitals have very active continuing education programs providing Category 1 credit to their staff members on a weekly basis. Another big problem is that of the speciality societies. Most of the speciality societies do conduct quite adequate programs for their members, and most physicians today would prefer to attend programs sponsored by their own speciality societies. This is particularly true for members of the American Academy of Family Practice. Communications with the AMA staff indicate that they too, are feeling this "crunch," and that some innovative ideas must be considered in order to compete for postgraduate continuing education dollars.

1979 PROGRAM

For 1979, your committee has tentatively made plans to have a third joint program with the AMA, October 21 through the 26th, 1979, at the newly expanded Hawaiian Regent Hotel. The number of postgraduate courses will be reduced to 12, and the courses will be so designed to be completed within a five hour period in one day, thus allowing us a better choice of faculty and also allowing members a greater variety of courses that can be attended.

Recommendations:

(1) Continue with the AMA Sponsorship of the Postgraduate Program and other portions of the scientific program.
(2) To further develop innovative programs in future years that would be attractive to our members as well as to our mainland colleagues.

HERBERT S. UEMURA, M.D.

Publications

The Publications Committee continues to supervise publication of the HAWAII MEDICAL JOURNAL and the HMA Roster.

In response to a request from the 1977 House of Delegates, the committee authorized an increase in scientific material to 2 moderate or 3 short articles per issue. The alternative of charging an author for lengthy articles was discussed and discarded.

A special subscription rate for University of Hawaii medical students was established. So far no students have subscribed.

Continued, and partly successful efforts are being made to solicit subscriptions from non-members of HMA.

Specialty societies have been asked to submit newsletters for publication (as the HAFP does) in an effort to increase the journal's information role.

So far, efforts to recruit a columnist for "What's new in medicine" or "practice pearls" have been unsuccessful.

The Roster should be completed by late October or early November 1978. This publication presents no problems.

The committee recommends continued publication of the Journal and the Roster.

WILLIAM F. MOORE, JR., M.D.

Self Insurance (Ad Hoc)

ACTION: That the Ad Hoc Committee on Self Insurance continue to function and that the report be filed.

The Self Insurance Committee has been meeting regularly and is pursuing alternatives for insurance, some of which look very promising. We are actively pursuing one plan and hope to have more information in the next few months.

MAURICE W. NICHOLSON, M.D.

Ad Hoc Committee to Amend Act 219

ACTION: That the Ad Hoc Committee continue to function, that it be given the responsibility of developing the monitoring mechanism, noted in its report, that this committee assess the possibility of its becoming a standing committee under the Legislative Commission, and that the report be approved.

I was appointed by the Legislative Committee to oversee medical malpractice issues through the 1977 session of the Hawaii State Legislature (Act 219). A formal subcommittee was never formed as previous communications with key legislators strongly conveyed the mood that the Legislature would not be receptive to further modification of the medical malpractice law until sufficient time had elapsed to observe the working of the law as it now stands. Interviews held with several malpractice defense attorneys, the administrator of the Claims Conciliation Panel (Mr. Bert Tomasu), and participation on Dr. Albert Chun-Hoon's Ad Hoc Committee of the Board of Medical Examiners to define Informed Consent led to the following conclusions:

(1) The Claims Conciliation Panels were working effectively and achieving resolution in the majority of cases heard.

(2) There was no experience as to court disposition of cases filed after Claims Conciliation Panel hearings.

(3) The Department of Regulatory Agencies appear to have little resource for or commitment to follow up and data gathering of the outcome of the Claims Conciliation Panel hearing process. To really discern the current malpractice mechanisms, we need to establish our own monitoring mechanism.

(4) There are major changes in the law that should be sought. The principles of collateral source and periodic payments should be pursued. The law currently defines lack of informed consent as a specific cause of action (e.g., without establishing any negligence), and this is a very poor legal concept that should be modified. The requirement of expert testimony to establish medical negligence is court established precedent that needs to be codified.

(5) We need to assure ourselves that the state-run Patient Compensation Fund is equitably operated (e.g., mechanism for entering and leaving the fund, reimbursement of current assessees after the corpus is established, etc.).

Recommendation:

(1) That HMA establish the above monitoring mechanism and continue the efforts of further legislative reform of the malpractice law in Hawaii working through the Legislative Committee.

E. LEE SIMMONS, M.D.

Legislative Commission

ACTION: Approved

Legislative Committee

The 1978 Session of the Hawaii State Legislature was very active and once again there were many bills and resolutions relating to health. The Legislative Committee met frequently and attempted to formulate position papers on the bills of major interest and concern to the association.

Dr. William Dang led the effort for the bills relating to the Emergency Medical Services program and funding has been assured for the continuation of the program for at least another year. He and his staff deserve a special vote of thanks for their yeoman efforts.

Dr. Roy Kuboyama worked very hard to achieve a statewide School Health Program. It has taken nearly ten years to achieve a permanent program in all schools and a lot of effort by Dr. Kuboyama, Dr. Sia, and the HMA School Health Committee.

Although the major efforts of the Association related to the EMS and School Health programs, there were several other areas of interest to the HMA which were successfully enacted:

- Definition of death
- Medicaid Fraud and Abuse
- Amendments re the Physician/Patient privilege in cases where the practice of the physician is at issue.

A generic drug bill introduced by the HMA was not reported out of committee; however, the Legislative Reference Bureau was directed to conduct a comprehensive study of generic drugs and the HMA will participate a survey of doctor's attitudes. Since there is growing interest in generic prescribing nationally, it would appear that this measure should be supported by the HMA again in 1979.

A vote of special thanks to the HMA Auxiliary who not only met prior to the session with various members of the Legislature but also spent many, many hours in monitoring hearings, screening health related bills, and other activities. We hope they again work with us in the 1979 Session.

Budget Request

Legal Counsel		$ 8,500.00
Dinner & Entertainment		—
Today's Health		300.00
Miscellaneous		400.00
Printing		1,500.00
Consultant		—
	Total	$10,700.00

Recommendation:

(1) That Mr. Kazuhisa Abe be retained as HMA Legislative Counsel for the next legislative session provided that the HMA Council approves the necessity of retaining a legislative counsel.

LEONARD HOWARD, M.D.
GEORGE GOTO, M.D., *Commissioner*

Medicaid Ad Hoc Committee

ACTION: That the committee continue to function and the report be approved.

The Medicaid Ad Hoc Committee met once during the year to determine alternative means to cut down on the cost of the Medicaid program. It was recognized that 51% of the cost was being spent on in-patient hospital care, increased elderly patient care, use of the premature intensive care unit, the use of more specialized diagnostic procedures, and care related to increased medical knowledge. It was decided that the only alternative this year seemed to be to examine abuses in the Medicaid system by patients and physicians. This alternative means was conveyed to the Department of Social Services and Housing and to the 1978 State Legislature. (The alternative in the House of Representatives was to cut down the payment to professionals by 50%.)

ROY KUBOYAMA, M.D.

Emerging Medical, Moral, and Legal Concerns

ACTION: Approved

The Ad Hoc Committee has continued to meet and evaluate the feasibility of establishing a counseling commission within the State. This was approved in concept at the last meeting of the House of Delegates. Debate has centered around where this commission should be structured, i.e. state government or within HMA. The prevailing opinion has been that it should remain within the HMA. With this in mind a budget has been developed to provide seed money to establish the commission and make it operational. It has been the consensus of opinion that there should only be one committee statewide rather than one at each hospital because of lack of expertise in several areas. It is anticipated that the commission would be made available to any hospital, physician, family, lawyer or court for its counseling role.

Budget Request

Part-time secretarial support (keep minutes, type reports, schedule meetings)	$2,000.00
Consultation (two experts from the East Coast, round-trip air fare, 2 days work, and per diem)	1,800.00
Travel (inter-island only, four people to three islands twice a year, round-trip plus per diem)	1,200.00
Equipment (tape recorder-$500, file cabinet with lock and key-$100, cabinet or bookshelf-$100)	700.00
Stationery and Supplies (150 hours of tape, stationery, etc.)	150.00
Postage, Printing, Telephone	150.00
TOTAL	$6,000.00

Recommendations:

(1) Approve concept of establishing commission within HMA.
(2) Approve budget for its support.

ARNOLD W. SIEMSEN, M.D.

Hawaii County Medical Society

ACTION: Filed

The Hawaii County Medical Society continued to decline in membership during 1978 and no new members have joined the society in the past three years. Based on a survey of members and non-member physicians in the county, the major causes of the decline are (1) Ineffective peer review activities, (2) The building fund (Dang Plan), (3) No recognizable benefits from the major portion of dues assigned to Hawaii Medical Association and the American Medical Association.

The society has revised its by-laws to permit referral to HMA of any peer review complaint in which the society is unable to manage a fair and impartial investigation. The society has incorporated as a not-for-profit corporation to minimize legal liabilities growing out of peer review activities.

A membership drive is being planned to attempt to reverse the decline in membership.

JAMES R. WILLIAMS, M.D.

Honolulu County Medical Society

ACTION: Approved as amended.

The major activities of the Honolulu County Medical Society during 1978 were dictated primarily from ideas developed from an Open Forum held in September of 1977. From this forum, the major problems facing the HCMS were delineated, and an attempt was made to find solutions to these problems.

The regular standing committees operated in their usual fashion, and their functions were carried out in very good fashion for the most part. However, increased emphasis was placed particularly in the Program Committee and also on two new ad hoc committees, the Public Relations Committee and the Community Action Committee.

The Program Committee worked hard in developing interesting programs. Also, a trial at evening dinner meetings with spouses invited, was made and indeed has been quite successful in getting more members out to meetings. Thus, increasing the quality of and attendance at membership meetings was one major goal and, in my opinion, has been relatively successful.

A second major area of emphasis was in Public Relations. This involved improving our public image, better communication with our members and also in community action programs. A major improvement in the area of PR was the hiring of a full-time public relations specialist who will be used jointly by the HCMS and HMA. Since her arrival on staff in June of 1978, Ceci Young has been invaluable and energetic in helping us develop our PR program. We have improved our "Green Sheet," Board of Governors Bulletin, so it is now more informational to the membership. Actions of the various committees, Board of Governors, and results of polls, etc. have all been published so that the membership might know what is going on.

The Public Relations Committee has developed a pamphlet for physician use in their offices entitled "Hawaii Health Tips." This pamphlet will have short articles on a variety of health topics plus articles of a socioeconomic nature so that we can better keep our patients informed as to what physicians are doing, etc. The PR Committee is at present involved in planning for a booth at the College Careers Day to be held in October. Work in this area has been spearheaded by two of our *new members* in the Medical Society.

Communication with our members has also been undertaken by the use of polls. We have received excellent responses in our polls, especially as the year has progressed, indicating, at least, some interest on the part of the members. Our membership was polled on the controversial issue of Unit Rule or Mandatory AMA membership, and subsequently, a special meeting was held to discuss this issue. A non-membership poll was also very revealing as to why members drop out of the Society or never join at all. A final poll asking the membership how they felt about calling for a referendum on the unit rule issue received an 80%+ response, and the membership was 4½ to 1 in favor of calling for a referendum. Allowing the membership to vote on any and all *major issues*, especially if controversial, is certainly required if we are to remain *credible* with our members.

Also, to improve communication to and from the HMA, the HCMS councilors to the HMA have been invited to attend all Board of Governors meetings and make regular reports to the Board on HMA Council activities.

A second new ad hoc committee, the Community Action Committee, delved into areas such as health care for the elderly, CPR Training for high school level coaches in various sports and development of a brochure, to be used by physi-

cians, which would list all of the available health services in Hawaii. This Committee, however, because of its recent creation, is now in the process of reevaluation of its goals and functions. It is still considered to be of great import but its direction has to be better defined.

A third ad hoc committee, the Council of Medical Specialties, was formed for the purpose of better understanding of the problems of the various specialties, and hopefully to use the strength of these societies to promote communication and to strengthen the total HCMS body. The idea of specialty representation on the Board of Governors was widely discussed at the ad hoc meetings, in the Board of Governors and through the Green Sheet Board of Governors Bulletin. Because of the marked enthusiasm of the various specialties and the people they represent, it was decided to attempt to reorganize the HCMS Board of Governors so that each "qualified" specialty would have one representative regardless of size on the Board. Also an "at large" category was to be created to represent those not identified with a specialty. This idea is well along the way into becoming a reality which hopefully will be accomplished by December 1, 1978.

Finally, in July a "Recruitment Committee" was formed that met monthly to study the reasons why we are losing old members, to list and discuss the positive services which the HCMS, HMA, and AMA now give our members, and to develop new ideas as to ways we can better serve our members. A brochure will be developed listing these services, so that a more aggressive attempt can be made to both recruit new members and to regain many of our "dropouts." Recruitment should be done on a one-to-one basis. In view of our increasing loss of members in recent years, this committee is now being given top priority. We hope the brochure to be developed can be used by any HCMS or HMA member to recruit new members. In closing, I would like to say that the year has been a challenging one and also a rewarding one.

Recommendations:

(1) Communication with the membership should be vastly improved by:
 a) Direct mailing on a regular basis from the HMA on important issues before the Council or committees.
 b) Improved communication from HMA to the Counties and vice versa so that the counties can pass on this communication to its members. (Many important decisions are made without membership ever knowing why they were made.)

(2) If feasible, programs and policies developed by the HMA should be implemented through the county societies so that membership will be more directly involved.

(3) The HMA should have as one of its top priorities that of helping the county societies in an intensive recruitment effort so that the downward trend in membership can be stopped.

PATRICK J. WALSH, M.D.

Maui County Medical Society

ACTION: Filed

The Maui County Medical Society continued its active role in medical organization, function and planning on the Island of Maui.

During the past year, the Medical Society has met each month with the exception of two months during the summer of 1978. The basic thrust of the Medical Society during this current year has been:

1. To stimulate and encourage improvement of Medical Practice on Maui, largely through improvement in our function at Maui Memorial Hospital.

2. To encourage and maintain member participation in the County Council for state health planning.

3. To assist and guide in the formation of an effective emergency medical system for the Island of Maui.

4. To encourage members to actively participate in community service outside of medical practice.

In regard to the future, I believe that the programs under way should be maintained, and that wherever possible, the function of the Medical Society should be enlarged, specifically in regard to the emergency medical system and to community health planning. Also, it is my hope that in the coming year an active program be initiated to encourage more physicians in the community to join the medical society. Quite obviously, to maintain our professional integrity and our freedom of medical practice, we must have a strong and active membership with wide representation.

RUSSELL T. STODD, M.D.

Ad Hoc Committee on County/State Relationship

ACTION: Approved as amended.

This Committee was appointed by the President to increase HMA assistance to the county societies. Areas of concern presented to the Committee were expected to originate from within the county societies directly or in response to HMA inquiries. A letter was circulated to each county society inviting its participation, with a suggestion that the Committee re-examine the constitutionality of the peer review systems as presently provided in county society by-laws. No responses were received concerning either the suggested subject matter or any other problem areas.

Recommendations:

(1) That this Ad Hoc Committee not be continued.

(2) That a review of the county societies' by-laws concerning peer review be undertaken by the Peer Review Committee of the HMA.

(3) That an annual review of HMA's organizational structure and the function of its committees be undertaken in the spring of each year and that proposed changes be submitted to the county societies for feedback in sufficient time to permit formulation of appropriate recommendations to be submitted to the House of Delegates at the Annual Meeting.

ANN B. CATTS, M.D.

Resolution No. 1

ACTION: Not Adopted

Re: Proposed Amendment to the Bylaws of the Hawaii Medical Association Regarding Membership

Be it *resolved*, that the HMA Bylaws, Section 2.01 be changed as follows:

(Proposed deletion crossed out ~~thus~~)

2.01 Every member in good standing of a component society of this Association shall be a member of this Association ~~and the American Medical Association,~~ either as an active, special, or service member. (No further changes to end of Section 2.01.)

PATRICK J. WALSH, M.D.

Resolution No. 2

ACTION: Not Adopted

Re: Call for General Referendum (Section 4.100 HMA Bylaws) on Issue of **Mandatory AMA Membership**

WHEREAS, the **HMA** has had a **serious loss of members** in the past 2-3 years to the point where we now **represent only 60%** of our practicing physicians, and

WHEREAS, this **low percentage** of representation greatly **reduces** our credibility as the **representative** of **Hawaii Doctors** in our dealings with the Legislature, government and other fiscal agencies, and

WHEREAS, the issue of Unit Rule or mandatory AMA membership has **continued** to be one of the **major reasons** for loss of members and failure to recruit **new members** to the HMA, and

WHEREAS, **recent** polls of the Honolulu County Medical Society on two separate occasions, one 3 years ago and the last in January 1978, **representing 70%** of HCMS members, have shown that a **2 to 1** majority (67%) favor "voluntary" AMA membership, and

WHEREAS, **two separate votes** at "Special" meetings of the HCMS dealing with this issue within the **past 12 months** have shown a majority of those present favored **voluntary** AMA membership, and

WHEREAS, a **significant** HCMS **non-member** poll in **January** of 1978 showed that the **major reason** for **continued non-membership** in the HMA to be the "unit rule," and

WHEREAS, an **almost unanimous majority** of the HMA House of Delegates has **continued to vote in favor** of **unit rule** in recent years in spite of strong membership feelings against this controversial issue, and

WHEREAS, **decisions** on such **important** and often **controversial** issues **should be made by the membership at large, Be It Therefore**

Resolved, that this HMA House of Delegates meeting in October 1978 call for a **General Referendum** (HMA Bylaws Section 4.100) on the **issue** of **Mandatory AMA Membership,** and Be It Further

Resolved, that such question be sent by the **Secretary** to the **membership** for a vote **not later than 30 days from the date of this vote,** and Be It Further

Resolved, that the **results** of **such** a **vote by the membership** will be **effective** for the **next immediate fiscal year.**

PATRICK J. WALSH, M.D.

Resolution No. 4

ACTION: Adopted

Re: Unity

WHEREAS, the physicians in this country are being threatened with complete government control of the practice of medicine and Hawaii is no exception, and,

WHEREAS, this objective is clearly identified in PSRO legislation, Health Manpower legislation, National Health Insurance legislation, and the National Health Planning and Development Act (PL 93-641) and

WHEREAS, to divide and conquer is such a simple, fundamental and effective scheme, and

WHEREAS, unity of county medical society, state medical association, and the American Medical Association is the necessary strong triumvirate to fight governmental control, so therefore be it

Resolved, that this House of Delegates reaffirm its support of unified membership, and be it further

Resolved, that the delegates encourage non members to join, close ranks in unity for the difficult fight that exists now and in the future for the medical profession.

GEORGE H. MILLS, M.D.

Resolution No. 5

ACTION: Not Adopted

Re: The Office of Vice President

WHEREAS, the President of the Hawaii Medical Association at the end of this term of office is often at the peak of his effectiveness and productivity, and

WHEREAS, the present bylaws do not make it possible for the President to serve consecutive terms of office, therefore be it

Resolved, that the President of the Hawaii Medical Association be eligible for re-election to a consecutive term of office, and therefore be it

Resolved, that the words "Vice President" be substituted for the words "President Elect" wherever they appear in the present bylaws, and to make such other necessary changes as may be necessary to reflect the intent of this resolution.

Nominating Committee

Reference Committee on Public Health

Public Health Commission

ACTION: Approved as amended.

The Commission on Public Health consists of eight committees: Cancer, Chronic Illness, Communicable Disease, Crippled Children, Public Safety, School Health, Sports Medicine, and Substance Abuse. The committee reports are reprinted below.

Cancer

The first meeting of the Cancer Committee in 1978 brought members up-to-date on the recent developments with regards to the Cancer Center of Hawaii and during the second meeting, committee members met Dr. Thomas Hall, a prospective candidate for the position of the Director of the Community Based Cancer Control Program.

The committee has no recommendation for the House of Delegates at this time.

JOHN KEENAN, M.D.

Chronic Diseases

There have been no meetings of this committee during 1978.

The Chairman has stood ready to attend as HMA alternate to the Committee meetings of the Gerontology Center, and has discussed their proceedings with the HMA delegate, Dr. Charlotte Florine.

During the year there was a highly successful Symposium on the Geriatric Patient funded by Lederle Laboratories, and produced in cooperation with HMA, HNA and the Pharmaceutical Association.

The Chairman of Chronic Disease was involved in this, but as Chairman of the Utilization Review Committee of HCMS.

GLADYS C. FRYER, M.D.

Communicable Disease

The Communicable Disease Committee met twice during the past year on August 4, 1978 and on September 12, 1978 primarily to discuss Mandatory Premarital Rubella testing.

Representatives from the Pediatrics, Family Practice and Obstetrics and Gynecology Societies were present. The University of Hawaii Medical School and the Department of Health were represented.

During the August 4, 1978 meeting, it was generally agreed that the adult child-bearing women were still slightly more susceptible to rubella infection than the national average, but since the inception of the Rubella Vaccine in 1969, the susceptibility rate has dropped considerably. Strong objections were voiced against endorsing mandatory premarital rubella testing since present rubella testing and immunization have been performed by private physicians and the Department of Health clinics. It was voted to form 2 subcommittees, one to identify and educate the public gap group and the second to inform physicians regarding the importance of rubella immunization.

After a long and serious discussion, regarding the problem of rubella susceptibility of adult women of child-bearing age, the recommendation outlined below was passed by a majority vote of the Communicable Disease Committee to recommend to the HMA House of Delegates or HMA Council.

DENIS J. FU, M.D.

Recommendation:

(Note: This recommendation was not approved by the House of Delegates.)

(1) That HMA advocate mandatory pre-marital testing for Rubella.

Crippled Children

The Crippled Children Committee has met twice during the past year. Discussion during the initial meeting of the year concerned travel expenses for those physician consultants working with the Crippled Children Branch who travel to the neighbor islands and complete pediatric evaluation reports not being received by the Crippled Children Branch. At our meeting of March 16, we discussed development of a newborn screening program in order to detect metabolic disorders that could delay development. A Newborn Screening Committee was formed and has met only once. The committee, in the coming year, will continue to discuss a uniform newborn screening program for the state which will be presented to the Council for action next year.

D. V. Reddy, M.D.

Public Safety

The purpose of the Public Safety Committee is to serve as an advisory body to the Commission on Public Health on matters related to, but not limited to, automotive safety, water safety, and radiation. It is also to study legislation pertaining to medical aspects of public safety and to make recommendations. In addition, it is to work with appropriate doctors, hospitals, and government agencies in surveillance of radiation to insure safety to patients and personnel.

There were no meetings necessary during the year but the chairman was involved in testifying for the Citizen's Against Noise to the City Council and to the Legislature regarding alcohol and driving.

Truett V. Bennett

School Health

The School Committee met on two occasions in 1978.

SCHOOL HEALTH SERVICE PILOT PROGRAM:

Members of the committee testified before the state legislature to make the School Health Service Pilot Program permanent. The legislature appropriated funds to make the program, involving the public schools, permanent.

HEALTH EDUCATION:

We again supported the recommendation that health education be included in the curriculum for future elementary school teachers at the University of Hawaii.

This committee has no recommendations to the House of Delegates.

Ann Barbara Ho Yee, M.D.

Sports Medicine

The Sports Medicine Committee met several times during 1978 focusing on a seminar for athletic trainers and coaches. The Sports Medicine Seminar, held on May 5, 1978 at McKinley High School and organized by Dr. James Bennett, attracted approximately 75 participants. Participants reacted favorably, via a questionnaire distributed at the meeting, and many asked that this seminar become an annual event.

Recommendation:

It is recommended that the Sports Medicine Seminar be held on an annual basis.

Edward Kagihara, M.D.

Substance Abuse

The Substance Abuse Committee of the Hawaii Medical Association has functioned during the past year in three major areas:

(1) The bulk of the activity deals with the review of legislative resolutions and bills by the chairman and/or by members of the committee. The committee recommended that HMA support State Resolution 70 which requests study of the therapeutic effects of marijuana; at the same time, the committee recommended that HMA not support Senate Bill 1727 which set regulations on dispensing marijuana for therapeutic purposes.

(2) The committee assisted the Hawaii Society of Hospital Pharmacies who is in the process of developing patient package inserts which are written in the hopes that they will help improve patient compliance and understanding of the side effects of medications.

(3) The committee has continued to plan programs for the education of member physicians regarding substance abuse and toxicology and hopes that this can be incorporated into future HCMS programs.

James Lumeng, M.D.

Recommendation:

(1) That the Sports Medicine Seminar be held on an annual basis.

Roy Kuboyama, M.D.
Commissioner

Commission on Health Service and Care

ACTION: Approved as amended.

The Commission on Health Service and Care consists of three committees—Community Health Care, Health Manpower, and Disaster. The reports of these committees are reprinted below.

Donald F. B. Char, M.D.

Community Health Care

This has been an active, full year for the Community Health Care Committee. For the second year, the Committee worked upon setting up the basic machinery within HMA to grapple with the problems relating to implementation of PL 93-641 in our State.

Again, all HMA members who volunteered for this committee were accepted. In addition, all medical specialty organizations were contacted and invited to join in the work. All physicians participating in the organizational structure of the Subarea Councils (SAC) and State Health Coordinating Council (SHCC) were also contacted. The purpose of such moves were to ensure that all physicians who were involved or interested in this most crucial arena of health care planning could be made aware of the activities and could contribute to the work of this most important HMA committee.

Meetings were held monthly and the attendance and participation in the meetings were good. A list of accomplishments included:

(1) Many hours were consumed reacting to the original and revised drafts of the State Health Plan that was developed by SHPDA. In view of the newness of the concepts and pressing urgency of the matter, SHPDA staff were invited to join most of the meetings. This committee ultimately adopted many proposals for revisions and alterations to the State Health Plan, and this report was adopted by HMA for transmittal to SHPDA.

(2) Another activity generated by this committee involved requesting SHPDA to mail their monthly Health Planning News to all physicians in Hawaii. In view of the costs involved, SHPDA has mailed a copy of the Health Planning News to all practicing physicians, requesting

each physician to reply whether they wanted to be kept on the mailing list for this publication.

(3) Objected to SHPDA regarding proposed amendments to the Certificate of Need Rules whereby all equipment costing more than $150,000, even if the equipment is not used for diagnosis or treatment, will require a CON.

As one looks over the work of this committee, one must become deeply concerned that it cannot perform this job through this form of committee action alone.

It should be obvious to any physician currently that the government is beginning to control and manipulate the affairs of health care significantly. Fanning the flames of fear of inadequate or poor medical care for the masses coupled with soaring medical care costs, the medical profession is under full attack by these forces.

HMA must strengthen itself in contending with these socio-political pressures. It must more effectively coordinate and integrate the efforts of the physicians. It must allow all physician members to participate individually or collectively in these affairs of health planning. HMA must strive to unite and weld the medical forces into a strong, effective voice which can speak out for physicians strongly and clearly in these community planning processes.

HMA must recognize, however, that it must act speedily and expeditiously to cope with these matters. It currently is often bypassed and neglected because the internal communication systems of this organization are too ponderous and slow moving. In fact, it often lacks sufficient clarity as to how to route and deal with some of these problems.

It could, in fact, be pointed out that under this title of "Community Health Care," the majority of the affairs of HMA might be subsumed—an absurdity, but a point to keep in mind regarding the all-encompassing nature of this committee's potential importance for our organization.

There is a great need for the elected officers and staff of HMA to look more critically at this committee and its activities. During the past two years, the basic machinery and concepts have been set up for a democratic, open system involving all physicians who desire to understand or participate in community health care planning under PL 93-641.

Much more needs to be done to extend the role of the physician in the health care planning process. HMA must assume more responsibility in getting physicians to participate. More importantly, HMA must become more effective in countering undesirable programs; and in fact, it should be making proposals as to how to make health care planning more effective. Outside of a few individual physicians, medical voices are not being heard adequately in our state regarding all of our futures.

Recommendations:

(1) HMA must become more prominently involved in this political arena of health care planning.

(2) HMA must streamline and more clearly establish its procedures in this crucial area of health planning, and develop these processes more intimately into the everyday, ongoing functions of the organization. It should develop a high level, well-trained staff member to assist the President in coordinating and representing HMA in these matters in the community. The President's assistant could ensure ongoing, effective follow through and representation in many of the community councils where health care planning is being developed.

(3) HMA should develop its own health planning column for the entire membership. Most of these problems require speedy action, and are often closely linked to many other physician interests; for instance, a cancer program may involve many other committees such as Cancer, Continuing Medical Education, etc. All members need to be informed of upcoming issues and problems, and should be involved in developing appropriate physician responses on behalf of HMA.

(4) Certificate of Need (CON) activities must be confronted regularly. It is proposed by this Committee that each county society initially study these matters, and if they require statewide support or recognition, this problem could then be referred to this committee for further action.

(5) HMA must be more active in promoting physician viewpoints in the continuing discussions as to how to improve health care and minimize costs. The current state organization of SACs, SHPDA, and SHCC is too highly governmentally oriented and politicized and does not truly represent an equitable balance of interests and expertise in this most critical area of health care. We must get more physicians involved in these councils and task forces.

I would like to thank all of the members of this committee who have literally put in hundreds of uncompensated hours of study and work in this area of community health planning and who have contributed so much to make this committee a "live" and effective one.

DONALD F. B. CHAR, M.D.

Disaster

The Disaster Committee is scheduled to conduct a joint meeting with the HCMS Disaster Committee to discuss physician participation in the Regional Hospital Medical Disaster Exercise which will be held on October 18, 1978. This year's exercise will involve a simulated explosion and fire, producing damage and casualties at the Blaisdell Center Arena. The following objectives of the exercise are of major concern to physicians: (1) To reaffirm the purposes of the 1976 Statement of Understanding concerning emergency medical services during disasters and (2) To test the Honolulu County Medical Society's Plan for mobilizing physicians under simulated disaster conditions. As in the past, efforts will be coordinated with city, state, federal, military, and private agencies. It is anticipated that the Committee will provide assistance in triage and evaluation.

Recommendations:

(1) That future meetings and activities of this committee be coordinated with the Honolulu County Medical Society's Disaster Committee; and

(2) That the Disaster Committee continue to assist the counties in disaster exercises and planning activities and that efforts be made to develop a closer association with other counties' disaster committees.

MARTHA LOU HEFLEY, M.D.

Health Manpower/Health Care Costs

The Health Manpower/Health Care Costs Committee met twice during the year.

In January, President Hanlon assigned the Committee the task of reviewing the Summary Report of the National Commission on the Cost of Medical Care, which was appointed by the AMA and which had released the subject report in December 1977. Committee members were assigned to review each of the 48 recommendations in the report as a guide to our representatives to the AMA House of Delegates meeting in June. While the Committee could agree with some of the recommendations of the National Commission, it found others to be totally ineffective, already tried and dropped, already in use, counterproductive, or mutually conflicting with other recommendations. The results of this review are on file at the HMA Office.

In addition, the Committee conducted a survey of the membership on health care costs. The results of the poll are as follows:

(1) Do you think that total national outlay for health care is:

a) Too high	180
b) About right	141
c) Too low	34
d) Undecided	12
Total	367

(2) Do you think that health care cost can be reduced without sacrificing quality?

a) Yes	224
b) No	104
c) Undecided	14
Total	342

(3) Do you think reductions in health care costs should be achieved by:

a) Federal controls	12
b) State controls	10
c) Voluntary effort	260
d) All of above	26
e) None	18
f) Federal and State controls	2
g) Federal controls and Voluntary effort	6
h) State controls and Voluntary effort	8
Total	342

The Committee did not have an opportunity to discuss these results and the many suggestions contributed by the membership, however, it could be noted that the tabulation of the questionnaire returns contained many recommendations which deserve further study.

CLAUDE V. CAVER, M.D.

Report of HMA Appointees to Cancer Center of Hawaii

ACTION: Approved as amended.

There is no need for recapitulation of past events except to bring the House of Delegates up to date, since our last meeting.

There has been affirmation and reaffirmation by the University of Hawaii with organizations involved in the executive structure of the Cancer Research Center of Hawaii regarding the executive function of its Executive Committee. However, a revised grant proposal was submitted to NCI by the University of Hawaii changing the organizational structure and function of the Executive Committee to basically that of an advisory level.

On February 9, 1978, as a result of HMA Council action, a letter was written by the President of HMA withdrawing "support of and participation in the Cancer Center of Hawaii." It is recommended that all read this letter, a letter dated 9/7/77 written to our membership, and a letter written 4/3/78 to Senator Dan Inouye by our past president. The Board of the American Cancer Society, Hawaii Division, and Hospital Association of Hawaii subsequently took similar action. However, at the request of the University of Hawaii, American Cancer Society, Hawaii Division, is holding off final action for six months.

On May 8, 1978, unilaterally, the University of Hawaii by action of the Dean of Graduate Studies and Research, dissolved the Executive Committee.

Since agreements have been abrogated by the University of Hawaii, the HMA should make some final decision regarding the Tumor Registry.

HERBERT Y. H. CHINN, M.D.
THOMAS K. L. LAU, M.D.
ANDREW L. MORGAN, M.D.
HENRY T. OYAMA, M.D.

Commission on Continuing Education

ACTION: It was voted to commend Dr. Nadine Bruce for her work with the CME program and to approve the report.

PURPOSE

The purpose of the Committee on Continuing Medical Education is (1) to accredit medical institutions and societies for Continuing Medical Education according to the guidelines from the Liaison Committee on Medical Education; (2) to establish standards of Continuing Medical Education and encourage the development of high quality programs pertinent to the needs of local physicians; (3) to coordinate and publicize Continuing Medical Education activities within the State of Hawaii; and (4) to help physicians fulfill CME requirements for association membership and State relicensure.

ACTIVITIES

The Continuing Medical Education Committee met monthly this past year and has resurveyed and reaccredited the following hospitals and specialty societies: Hawaii Psychiatric Society; Queens' Medical Center; St. Francis Hospital; Straub Hospital; Wahiawa General Hospital; and G. N. Wilcox Memorial Hospital. The Committee surveyed and accredited Maui Memorial Hospital. The Committee also accredited the following programs for Category 1: Hawaii Medical Association Annual Meeting's State of the Arts Lectures; (Hospice); (Merck, Sharp & Dohme); (Hawaii Heart Assoc.); Society for Medical Technology's Medical Mycology Workshop; Honolulu County Medical Society's Conference on the Hospice.

In addition to the above, the CME Committee accomplished the following tasks this year:

(1) Efforts were made to refine the HMA-CME record-keeping system which has been in existence since January, 1977, and copies of 1977 CME records have been mailed without charge to HMA members.
(2) The Committee designed and approved printing of a HMA Physician's Recognition Certificate which is a CME certificate valid for one year and based on ⅓ of the credit hours required for the AMA-PRA. Applications for this certificate will be available in January, 1979.
(3) The Committee sent a questionnaire to members regarding individual CME status in hopes of identifying areas where physicians may need help. Approximately 25% of members indicated some need for help in understanding CME requirements. The Committee is now in the process of consulting with these individuals.
(4) The Committee has continued to review and keep up-to-date the calendar of CME events in the Hawaii Medical Journal.
(5) The Committee reaffirmed its support of mandatory CME and its acceptance of the AMA Physicians Recognition Award as the model for CME requirements.

Recommendations:

(1) that the HMA continue in its present role as an accrediting agent for the Liaison Committee on Continuing Medical Education.
(2) that the HMA reaffirm its support of mandatory CME.
(3) that the HMA take no punitive action against those members who are unable to fulfill CME requirements for membership by January, 1979, but extend help to those members in order that they will be able to meet the requirements in time for State relicensure in 1980.
(4) that the HMA continue to provide yearly printouts of CME records free of charge to its members.
(5) that the HMA provides the Physician Education Certificate free of charge to qualified members.
(6) that the HMA charge $10 for release of yearly CME records and $10 for application for the Physician Education Certificate to non-members.
(7) that the HMA investigate the cost and need for a computerized CME record-keeping system.

NADINE BRUCE, M.D.

Child Health Planning—Ad Hoc

ACTION: Approved as amended.

The AD HOC Committee on Child Health Planning held many meetings this past year to complete its initial Child Health Plan patterned after the Recommendations of PL 93-641. HMA members and guests from the Department of








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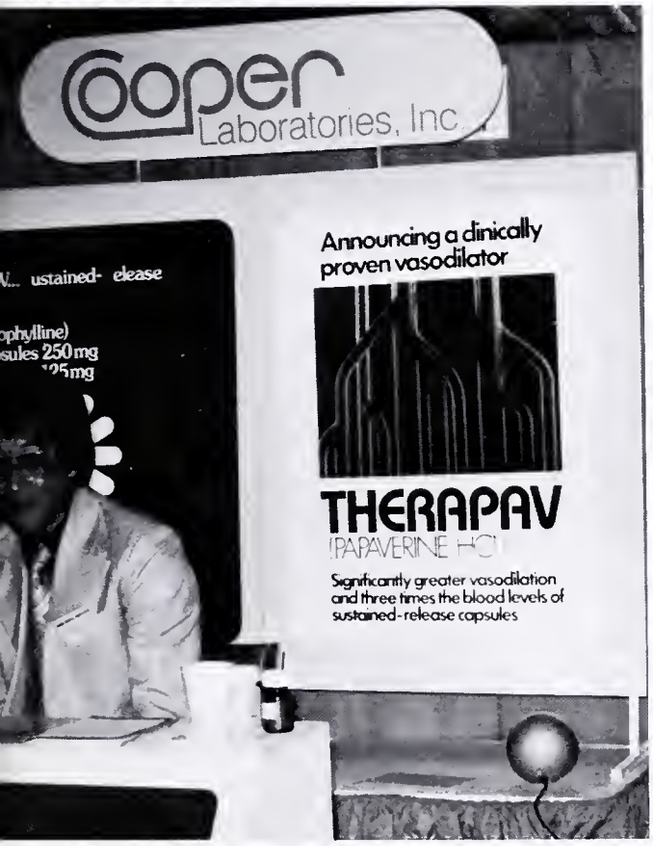

Pharmaceutical Products Division


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PHILADELPHIA,


SAN FRANCISCO
MEDICAL INSTRUMENTS INC
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CYCLO
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HOECHST-ROUSSEL
Announces a New topical
fluorinated corticosteroid
IN A UNIQUE EMOLLIENT CREAM BASE
NEW
TOPICORT
(DESONIMETASONE)
Emollient Cream
0.25%


Cooper
Laboratories, Inc.
Announcing a clinically
proven vasodilator
THERAPAV
(PAPAVERINE HCl)
Significantly greater vasodilation
and three times the blood levels of
sustained-release capsules


MSD MERCK SHARP & DOHME

Health Children's Health Services Division, Department of Pediatrics University of Hawaii School of Medicine, and Hawaii Chapter of the American Academy of Pediatrics worked diligently on the development of the plan.

The completed plan has been sent to each County Society, American Academy of Family Medicine, and others for comments. Thus far only the Hawaii County and Hawaiian Academy of Family Physicians have responded to the plan. It is the intention to submit the plan to the Hawaii Statewide Health Coordinating Council (HSHCC) and in turn to each Subarea Council for further discussion and implementation.

Recommendations:

(1) The AD HOC Committee be on call to discuss the various aspects of the Child Health Plan to the Subarea Councils and Hawaii Statewide Health Coordinating Council; and
(2) The Committee should also pursue the implementation of the plan.

CALVIN C. J. SIA, M.D.

Cancer Commission

ACTION: No report was submitted by the Cancer Commission, however, the House felt that administration should take appropriate action to see that the Cancer Commission meets its meeting requirements of 6 times per year as stated in the bylaws.

Voluntary Cost Containment

ACTION: Approved

HMA has joined the Hospital Association of Hawaii and the local offices of the Federation of American Hospitals in a voluntary effort to contain the escalation of hospital costs. This effort is in response to guidelines developed at a national level by AMA, AHA, and FAH.

Initial efforts were hampered by organizational difficulties but good progress is now being made and the reporting mechanism for obtaining necessary information from the hospitals in use.

The committee's original chairman, Mr. Duane Black, found it necessary to resign and the Committee is now under the able leadership of Dr. George Mills, Chairman, and Mr. Tom Battisto, Vice Chairman.

HMA members are Mrs. Becky Kendro and Drs. Rodney West and Marion Hanlon. Other members are from the HAH, FAH, HNA, and (other community groups).

Recommendations:

(1) HMA resolve to support the continual efforts of the Voluntary Cost Containment Committee.
(2) That HMA contribute its fair share financially and in kind service to support the Voluntary Cost Containment Committee.

MARION L. HANLON, M.D.

AMA Delegate

ACTION: Approved

Your HMA Delegate to the AMA attended the AMA House of Delegates, June 18-22, 1978, held in St. Louis, Missouri. This particular meeting was extraordinary in several respects: The AMA House had more than 300 recommendations, reports, and resolutions to deal with, by far the most business presented than any previous meeting; and, for the first time, specialty organizations were represented on a direct basis in the AMA House.

If there was a theme to the 1978 Annual Meeting, it would have to be "the cost of medical care." The AMA House took action on responses for the recommendations of the National Commission on the Cost of Medical Care, responded to a variety of resolutions related to cost, and heard incoming AMA President, Tom Nesbitt, M.D., of Nashville, Tennessee, call for physician fee restraint, which basically asked each physician to restrain the *rate of growth* (not reduce fees) by one percent each year over the next two years. This call for physician fee restraint is consistent with the AMA's involvement with the American Hospital Association and the Federation of American Hospitals in the "Voluntary Effort" Program. This VE activity is designed to achieve an annual two percent reduction in the growth of hospital costs over the next two years. The VE effort is already demonstrating an impact as the rate of growth in hospital costs appears to have declined by more than 2% in the first few months of this year.

Other major cost discussions centered around the forty-eight recommendations presented by the National Commission on the Cost of Medical Care (NCCMC), which, as you are aware, was established by the AMA in 1975 but as an *independent body.* The NCCMC presented a Summary Report in December, 1977, which contained 48 recommendations, several of them highly controversial. The AMA House directed the AMA Board of Trustees and its Councils to investigate and study this material and report to the House of Delegates on its responses to each of the recommendations. The material presented is voluminous—122 page report. To briefly summarize:

(1) The AMA House endorsed a statement that "The House of Delegates believes that the one hope for cost containment in the provision of health care lies in strengthening price consciousness in the health care marketplace." The AMA House thus recognized that all concerned must attempt to strike a balance between quality and cost, and that, at various times, there should be a sharing of responsibility for cost decisions.

(2) The House endorsed recommendations dealing with consumer price consciousness, including giving employees a periodic informed choice among various health care coverage options, giving employees economic incentives to shop for cost-effective health care coverage, and providing for employee participation in cost decisions through coinsurance and deductibles.

(3) Regarding recommendations dealing with the assessment of quality in medical care and the use of standards and guidelines, the House asked that the AMA Trustees and the Councils look further into this area and submit recommendations for consideration in the future.

(4) The House endorsed NCCMC recommendations urging experimentation with prospectively determined rates and other payment systems that can make the administration of health facilities more cost conscious. The House also endorsed the use of voluntary programs and incentives to limit bed capacity to the needs of the population served by individual hospitals and the use of experimental programs to decertify facilities that appear to be unnecessary.

(5) Several recommendations by the NCCMC addressed the matter of public utility regulation to which the House asked for a moratorium on new regulations in the health area and a thorough examination of existing regulations. (This fact of life is gaining increased attention in areas other than medicine.)

(6) Recommendations calling for standards for placement of expensive technical equipment and for the use of regional centers for high-cost specialized technologies were referred to the AMA Trustees for more study as was the question of the adequacy of the physician supply.

(7) The House adopted most of the concluding NCCMC recommendations which called for physicians to receive additional information about the cost of services, for rapid dissemination of information about new technologies, and for a broad new approach to patient education.

While impossible to give a total review of the scope of the Commission's report, this activity has given us much material for review in the future.

A second major issue before this session of the AMA House was a proposed revision to the Principles of Medical Ethics. This revision includes both an updating of the language to reflect more modern usage and a response to legal restric-

tions on the health professions that have been written into state laws over the years. Concern was expressed over the interpretation that could be given to some portions of the revised Principles, and the House voted to defer these revisions to an ad hoc committee of the House for study and report back at the next meeting of the House.

National Health Insurance (NHI) has received substantial attention by the AMA House in past sessions and this meeting was no different. Five resolutions dealing with NHI were referred to the AMA Trustees with the request that any AMA sponsored NHI proposal to be introduced in the Congress next year be circulated to the House in advance of the 1978 Interim Meeting.

Two other actions of the House merit attention. The House voted to offer membership at a 50% dues level to those physicians who are in their first year of practice, and the House approved the reorganization of the Student Business Section to provide for a representative assembly composed of voting delegates from each of our nation's medical schools.

This year's meeting also marked an end to a tradition. The large clinical meeting held in June has been discontinued in favor of an expanded number of regional CME programs as research studies indicated this approach better suited membership needs.

It is impossible (and much too time-consuming) to review all of the items considered by the AMA House. An excellent summary of House actions is contained in the June 30/July 7, 1978, Convention issue of the American Medical News. The Proceedings of the House of Delegates for this meeting is also available at the HMA office.

I wish to thank you for the privilege of allowing me to serve as your Delegate to the AMA. I am even more convinced now that the medical profession needs organized medicine, at the national, state, and county level, if the true needs of patients are to be met well. If any members have opinions regarding any facet of medical care, practice, or otherwise, please let me know.

Recommendations:

(1) That County medical societies be encouraged to allocate travel monies in their budgets to allow one or two county society officers or representatives to attend every AMA House of Delegates meeting.
(2) In light of the AMA action regarding physicians in their first year of practice, that physicians in their first year of practice he granted an HMA dues level of 50% of regular Active HMA dues, with guidelines to determine physicians in their first year of practice to be established hy the HMA Council.

HERBERT Y. H. CHINN, M.D.

Commission on Medical Services

ACTION: That the Fee Survey Report not be approved with regards to printing a new RVS and that the Workmen's Compensation Committee report be filed.

The Commission on Medical Services consists of the Fee Survey Committee, the Worker's Compensation Committee and the Economic Evaluation and Adjustment Committee. There was no business referred to the Economic Evaluation and Adjustment Committee which is essentially a Negotiating Committee. The report of the Fee Survey and Worker's Compensation Committees are reprinted helow:

WILLIAM W. L. DANG, M.D.

Fee Survey

The Fee Survey Committee has completed its revisions to the 1970 Hawaii Relative Value Studies and the document is ready for puhlication. The Committee feels strongly that the new RVS should be printed immediately. There are many new procedures and adjustments in relativity and this document is of great value to all practicing physicians. The Committee has asked for new estimates on printing of the document but as of this date the cost information has not been received. It is recommended that the House of Delegates include a printing budget of $20,000 in 1979 although the total cost is not expected to reach that amount.

MAURICE W. NICHOLSON, M.D.

Worker's Compensation

Although the Worker's Compensation Committee did not meet during the year, the chairman has provided assistance to the Department of Labor and to individual physicians as questions arose.

The HMA testified at the Worker's Compensation hearings on the medical fee schedule in December 1977 resulting in the publication of a new schedule effective January 1978. The new schedule shows a marked improvement from the previous schedule.

BERNARD SCHERMAN, M.D.

Bureau of Research and Planning

ACTION: Approved

The Bureau of Research and Planning has had two major meetings this past year. The initial meeting focused on the need to explore more avenues to deliver health services to immigrants. The exploration has led to the bigger question of whether an Independent Professional Agency (IPA) should be pursued by the Hawaii Medical Association. The Committee moved that HMA does explore the feasibility of establishing an IPA in Hawaii. It feels that a pluralistic system of delivery of health care should be made available to every citizen in Hawaii and that our physicians should be educated to the various options of health care delivery.

Recommendations:

(1) Active exploration of an IPA be made immediately with one invitation to Mr. Boyd Thompson; and
(2) Attendance at a national meeting on IPA by the executive director in Novemher.

CALVIN C. J. SIA, M.D.

Resolution No. 6

ACTION: Adopted as amended.

Re: Waiver of CME Requirements

WHEREAS, retired physicians in the State of Hawaii are finding it difficult to maintain permanent licenses due to increasing licensing fees and CME requirements, and

WHEREAS, retired physicians have given support and service to the Hawaii Medical Association during their active professional lives, be it

Resolved, that the Hawaii Medical Association waive medical licensure as a requirement for HMA membership for retired physicians who have been members in good standing in the Association prior to retirement, and be it further

Resolved, that the Hawaii Medical Association waive the membership CME requirements for those retired members who elect not to maintain a permanent medical license.

NADINE BRUCE, M.D.

Resolution No. 9

ACTION: Adopted as amended.

Re: Voluntary Cost Containment

WHEREAS, the American Hospital Association, the American Medical Association, and the Federation of American Hospitals, in recognition of the need to restrain the rate of increase in health care expenditures, agreed to organize a Voluntary Cost Containment Program known as "The Voluntary Effort," and

WHEREAS, a coalition of Hawaii hospitals, doctors, insurers, nurses, labor, business, government, and concerned private citizens is thoroughly in agreement with the steps that have been taken at the national level, and

WHEREAS, this coalition has pledged support and demonstrated concern for containing health care costs by forming and participating in Hawaii's Voluntary Cost Containment Committee, and

WHEREAS, the first part of Hawaii's Voluntary Effort will be to monitor the operating expenses of Hawaii hospitals with the goal of a 2% aggregate reduction in the rate of increase in hospital expenses, and

WHEREAS, the Voluntary Effort must include all segments of the health care delivery system including suppliers, doctors, government, and hospital personnel, as well as consumers of medical services, now therefore be it

Resolved, that the Hawaii Medical Association strongly support the program of the Hawaii Voluntary Cost Containment Committee and continue to play a leadership role in demonstrating the value of voluntary action in cost containment, without sacrifice in quality of medical care.

GEORGE H. MILLS, M.D.

Resolution No. 10

ACTION: Adopted

Re: Mandatory Pre-Marital Rubella Testing

WHEREAS, Rubella is considered a common childhood illness which has been preventable by Rubella vaccine in 95% of the susceptible persons and has been available since 1969; and

WHEREAS, the susceptability rate of the adult female in the child-bearing age group in the State of Hawaii has dropped from 54% in 1970, to 50% in 1972, to 39% in 1976, and 37% in 1977; and

WHEREAS, the increased awareness of the private medical physicians has contributed to the decline of the Rubella susceptibility rate; and

WHEREAS, The School Health Service Program which became permanent in 1978, alerts parents of children who have not been immunized and

WHEREAS, compulsory immunization, which includes Rubella, is necessary by law before a child is admitted to school and

WHEREAS, mandatory pre-marital Rubella testing would be testing about two-thirds of the non-susceptible adult females, thereby increasing the cost of medical care

Therefore, be it Resolved that the HMA be opposed to all legislative proposals to permit mandatory pre-marital screening for Rubella and recommend that the pre-marital Rubella testing be done on a voluntary basis.

DENIS FU, M.D.
Chairman, Communicable Disease Committee

ROY KUBOYAMA, M.D.
Commissioner of Public Health

Reference Committee on Finance

Commission on Interprofessional and Public Affairs

ACTION: Approved

The Commission on Interprofessional and Public Affairs consists of two committees: Public Affairs which also includes the Tel-Med functions, and Television-Radio. The reports of these committees are listed below.

PHILIP R. MCNAMEE, M.D.

Tel-Med

The Tel-Med Program, a collection of tape recorded health messages available to the public by telephone, continues to gain popularity with phone calls averaging between 450-500 per day. The program was expanded to the neighbor islands in February 1978, allowing calls to be made toll free, and there are now over 2,000 calls per week from this area. Foreign language tapes are planned for the very near future on selected topics. The program is jointly sponsored by HMSA and HMA. HMSA has included Tel-Med information as a part of their regularly sponsored newscast and Tel-Med information now appears on all television channels.

Recommendation:

Inasmuch as the contract between HMA and HMSA for sponsorship of the Tel-Med program will expire in December 1978, it is recommended that the HMA House of Delegates go on record in favor of continuing the joint effort and sponsorship of the Tel-Med program.

The budget for the continuation of the Tel-Med program is included in the Public Affairs budget request.

Public Affairs

The committee met monthly. A number of projects were undertaken and completed. The committee:

(1) Jointly sponsored with Hawaii Newspaper Agency two Public Forums "Coping with Cancer" and "Diabetes—A Family Affair." Both were well attended.
(2) Revised the publicity code which was approved by the HMA Council.
(3) Provided physicians as judges for the Hawaiian Science and Engineering Fair. Also provided multiple prizes totaling $400.
(4) Provided scientific review and editing of Tel-Med tapes.
(5) Selected the HMA Physician of the Year—(Robins Award).
(6) Selected the two HMA Awards for Medical Reporting.
(7) Approved and supported the concept of a full time Public Relations position in the HMA.

In addition, the committee met with Ms. Barbara Chapman, Associate Director of Public Relations of the AMA, during her visit here from Chicago.

A future project will be the development of an appropriate celebration of the 125th Anniversary of the HMA in 1981.

The budget request for Public Affairs, TV-Radio, and Tel-Med is included in the 1979 budget proposal submitted by the Treasurer and Finance Committee.

PHILIP R. MCNAMEE, M.D.

TV-Radio

The TV-Radio Committee has met regularly and has continued production of the one-half hour health education series "Health Conversation" or "Your Body, Your Mind," ably moderated by Ron Pion and John Corboy. The series was first started in 1976 through the cooperation of Oceanic Cable Vision. From July to December 1977 production was continued by Punahou School as a free public service. Punahou School TV officials found the costs to be prohibitive and advised us that we will be charged $350.00 per one-half hour program starting in January. Fortunately the House of Delegates had appropriated a $3,000 budget for the committee, so with careful negotiation and budgeting, the Committee was able to continue uninterrupted production through the private firm, O'Kelley Productions at the rate of $55 per one-half hour program plus cost of the ¾-inch video tape. The programs have continued to be circulated through all the cable vision stations in the State and the DOE has been making a program duplicate for its library and for dissemination through the school system upon request.

For the coming year 1978-79, we fortunately received a $15,000 grant from the Chamber of Commerce of Hawaii Health Fund solely through the efforts of our Public Affairs Commissioner Phil McNamee. With this grant assured, the Committee was able to meet with KHET officials Mary Bitterman and Charles Stubblefield who have assured us a

Saturday 1 p.m. showing starting October 7 this year and negotiate with Punahou School TV production officials Paul Berry and Henry Fordham for production of high quality one-half hour programs with the same format (Cost: 40 programs for $13,000 and the remaining sum to be used for special set construction, music copyright fees and for advertising). At present, the Committee's real concern is for the next fiscal year 1979-80 when the grant monies run out. The committee at this time requests a budget of $3,000 for unforeseen expenses, any surplus which can be transferred to the next fiscal year.

The Japanese Speakers Bureau continues to successfully educate and entertain the Japanese speaking public with its weekly radio call-in programs on KOHO (Monday evening 7:15 to 8:00 p.m.) and on KZOO (Tuesday afternoons, 1:30 p.m. to 2:00 p.m.).

HENRY YOKOYAMA, M.D.

President's Report

ACTION: Approved as amended.

Chronologically, this has been a short year, but it has been a full year with several important issues to be dealt with. A few solved or quiescent, but most of the issues still face the Association.

As HMA President, I have been involved in several interesting, and hopefully, helpful conferences. In addition to the usual annual and interim sessions of the AMA House of Delegates, I have attended the AMA Leadership Conference and the AMA-Kennedy jointly sponsored conference entitled, "Focus in Positive Health Strategies." They both were of considerable value but the Leadership Conference should, in my opinion, be more widely attended by our local county and state leadership.

An additional pleasure was that of being one of several HMA members involved in the Hiroshima Prefecture Medical Association meeting in November. I hope our new sister relationship can be nurtured in the years to come.

It is a pleasure to report that HMA is now officially free from the tri-partite agreement that bound us to unwanted responsibilities for the Mabel Smyth Building.

Our problems with the Cancer Center of Hawaii are not so completely solved, but it is with some relief that I can report that HMA no longer officially supports or participates in the Cancer Center. However, cancer is still with us; and as a result, as physicians working in this community, we cannot completely divorce ourselves from the cancer control programs in Hawaii. The HMA Council will need to deal with associated problems as they crop up and, in the very near future, must make some crucial decisions regarding the location and funding of the Hawaii Medical Association's Tumor Registry. The Registry is now an incorporated entity with the HMA Council members designated as the corporation membership.

Under the able direction of the Continuing Medical Education Committee and the diligent chairperson, Dr. Nadine Bruce, the multiple problems generated by mandatory CME are beginning to fall in place. I would hope that the efforts of HMA include a careful look at the value of mandatory CME and, if indicated, strong support to remove this mandatory requirement.

Escalating costs of medical care are of great concern nationwide. HMA, through its Health Manpower and Health Care Costs Committee, is attempting to address this issue as is the Voluntary Effort Cost Containment Committee which is a joint community effort spearheaded by the Hospital Association of Hawaii and HMA. Under the able leadership of its chairman, Dr. George Mills, this committee is beginning to make progress, and HMA will continue to support the Committee's efforts financially and with inkind services.

However, the responsibility for cost control ultimately must be faced by each practicing physician. We must examine our own role by becoming aware of the price tag on services and procedures and by carefully examining the cost effectiveness (a dirty term, I know) of the multiple tests, procedures, and treatments we order. If we don't, "Big Brother" will.

The HMA-EMS Program is another aspect of our program that needs consideration. A "blue ribbon" committee recently recommended reorganization of the relationship between HMA and EMS.

The report of the Building Committee will be found elsewhere in your handbook. As a whole, I feel it is a success story that should be reported to those physicians who expressed opposition to our move.

The Fee Survey Committee reports that the revised Hawaii Procedural Code and Terminology (previously known as Hawaii RVS) is now ready for publication. Such publication has been postponed because of Federal Trade Commission (FTC) intimidation of other medical societies. This revision contains many changes and additions which should be made known to the membership.

As President of HMA, it has been, at times, difficult for me to delineate the duties of the President, especially in relation to the duties of the Council. As stated in the Bylaws of the HMA, the President conducts meetings and otherwise serves only as a figurehead. In reality, the job is not this simple. Therefore, I will suggest that our present Bylaws be examined in order to see if they truly reflect the functions of the Council and the President as they are being carried out at this time.

Finally, of major concern to me and to our staff is the declining membership. At a time when forces of opposition to our present system of high quality medical care are gaining strength, it seems incongruous that we, who are so vitally involved, are allowing our clout to be dissipated. It is a time when physicians should be closing ranks, rather than abandoning the ship.

I would be remiss if I did not thank you, the members of HMA, for your support and encouragement this past year. Especially, however, I wish to thank the HMA staff who have so patiently and loyally served me and all of you in HMA.

Recommendations:

(1) That HMA, at budgetary discretion, send each incoming President and members of the executive staff to the AMA Leadership Conference and that the County Societies be encouraged to send, annually, their President or President-Elect.
(2) That serious consideration be given to the retention of the Tumor Registry in the HMA building.
(3) That HMA actively pursue methods for containing the escalating costs of medical care.
(4) That the relationship between the EMS Program and HMA be seriously considered and resolved by the Council.
(5) That the Bylaws Committee and the past five presidents conduct a thorough review of the Bylaws relating to the functions of the Council and the President.

MARION L. HANLON, M.D., M.P.H.

Secretary's Report

ACTION: Filed. The minutes of all Council meetings were ratified as circulated.

The total membership of the Association as of December 31, 1977 was 928, a decrease of 79 compared to December 31, 1976 which was 1,007. The special members numbered 31, a decrease of 10 from the previous year. A dues waiver (retirement, life members, and financial hardship) was granted to 137 members, an increase of 11 over the previous year.

One member died since the last annual meeting: Dr. Leoncio DeJoya.

By counties, the active membership was made up as follows as of December 31, 1977:

County	Active Dues Paying	Active Dues Waived	Special	Total
Honolulu	625	112	30	767
Hawaii	61	13	1	75
Maui	59	6		65
Kauai	15	6		21
	760	137	31	928

As of August 31, 1978, the membership has decreased to a total of 895 with 715 Active Dues Paying, 148 Active Dues Waived, 32 Special Members.

Since the last annual meeting there have been 9 Council meetings that were held as follows: January 6, February 3, March 3, April 7, May 5, June 3, July 7, August 4 and September 1, 1978. (The minutes of all Council meetings were enclosed for ratification by the House of Delegates.)

DOUGLAS B. BELL II, M.D.

Treasurer's and Finance Report

ACTION: Approved as amended.

As your Treasurer of the HMA and Chairman of the Finance Committee of the HMA, I am presenting this combined report including the HMA Council Approved 1979 Budget for the HMA. Your HMA is in sound financial condition at this time. Like most growing organizations, finances are always in the spotlight. This year is no different in this regard for HMA.

It appears that our federal projects, under or related to HMA, have provided us with an opportunity for both growing pains as well as financial growth. The termination of federal support for the HMA-EMS program during 1978 was not unexpected. It does provide HMA the opportunity to look at the finances of HMA without such a large amount of federal dollars both in and out. Pacific PSRO and its activities under a shared arrangement with HMA has provided considerable impact on the HMA budget but not necessarily a "gain" as the monies reflected are basically "in and out" monies whereby HMA is only a funding pass-through agency for the PSRO.

Your Treasurer and Finance Committee have diligently looked after the financial affairs and monies of your HMA. It appears that our dismal-looking deficit budget adopted by last year's HMA House of Delegates will not occur but, instead, a substantial addition to members' equity will be realized in 1978.

For 1979, your Treasurer and Finance Committee developed and refined in detail a budget to recommend to the HMA Council for referral to the HMA House of Delegates. The Finance Committee recommended a budget with a potential deficit of some $15,000. The HMA Council considered the recommended budget along with some late requests for monies in 1979. The HMA Council then adopted a budget with a deficit of $33,985 for referral to the HMA House of Delegates. This budget is attached to this report. Detailed explanatory notes to each of the items under the Income and Expense sections were presented to the Council by the Finance Committee. These explanatory notes have not been made a part of this report due to their length; however, the notes are available to any delegate who wishes to pursue them.

In presenting this budget to the HMA House of Delegates, the HMA Council has made certain assumptions to ascertain the budget figures. These assumptions are contained in the following recommendations to the HMA House of Delegates for adoption.

Recommendations:

(1) It is recommended that the HMA dues for Active members remain at $240.
(2) That, recognizing that HMA Special members are waived from the $250 AMA dues, and recognizing that the benefits for HMA Special members are the same as HMA Active members with the exception that HMA Special members cannot hold any of the four elected officer positions, it is recommended that dues for HMA Special members be $240.
(3) It is recommended that the registration fee for the HMA members at the HMA Annual Meeting continue to be waived and that the general registration fee for non-member physicians at $25.
(4) It is recommended that the 1979 Roster be handled so that each HMA member receive one copy free of charge, that HMA members wishing additional copies be charged $10 for each additional copy, and that non-member physicians or other interested parties be charged $20 per copy.
(5) It is recommended that the HMA Roster, after 1979, be published on a biennial basis (i.e. every two years).
(6) It is recommended that the charge of $100 for CME approval for specialty societies remain in effect, and that a minimum of $250 be charged for surveys of hospitals, plus travel costs, if any.
(7) It is recommended that a contract for services provided in 1979 to the Honolulu County Medical Society

1979 Budget
Hawaii Medical Association

INCOME	Estimated 1978	1978 Budget	1979 Budget
Dues	173,000	189,750	183,800
Journal	60,000	60,000	60,000
Annual Meeting	18,000	24,500	22,000
Annual Roster	1,000	1,500	2,000
Indirect Costs—EMS	115,000	- 0 -	- 0 -
Indirect Costs—HTR	40,000	- 0 -	- 0 -
Indirect Costs—EMS (State)	- 0 -	- 0 -	- 0 -
Interest Earned	6,000	3,500	13,000
Miscellaneous	100	100	100
Dues Collection Service	1,300	1,500	1,500
PSRO Salary Reimbursement	190,000	234,900	223,000
PSRO Services Reimbursement	55,000	55,500	43,800
EMS Accounting Service	5,000	- 0 -	5,000
Fee Survey	450	5,000	- 0 -
Continuing Medical Education	1,000	1,000	1,500
Printing & Xeroxing	4,400	4,500	4,500
Contract Services, HCMS	72,500	72,500	82,400
Other Reimbursed Revenues	100	1,200	10,500
Travel Reimbursement—HTR	- 0 -	8,000	- 0 -
PSRO Reimbur. Mtg. Expenses	6,000	5,000	7,000
Retirement Reimbursement	- 0 -	- 0 -	123,365
TOTAL INCOME	$748,850	$668,450	$783,465

be adopted for an annual payment of $82,400, subject to negotiation and approval by the HMA Council.

(8) It is recommended that the House of Delegates approve an increase in the allotment to the HMA Auxiliary for 1979, from $11 per HMA member to $15 per HMA member.

(9) As the budget considered by the Finance Committee and the Council inadvertently omitted the line item for HAMPAC for educational purposes, your Treasurer recommends that the line item for HAMPAC be adopted with a budget of $1,000.

(10) It is recommended that the House of Delegates adopt this 1979 budget as presented.

WILLIAM HINDLE, M.D.

Building

ACTION: Approved

In its second year of full operation, the HMA building continues to demonstrate its value to the membership. HMA meetings or meetings related to HMA activities and concerns continue at a high tempo and result in high usage figures for HMA's building. From September, 1977, through August, 1978, 568 meetings were scheduled in the HMA building. This does not take into account those unscheduled or conference meetings that so often occur. The HMA's space requirements have increased also, and several staff members have been relocated to Suite 204 which had served as an HMA storage room.

High utilization of our building has created its own set of problems, especially with regard to parking. Large committees, or multiple committee meetings, especially at noon, have been a cause of frustration not only to HMA members but to tenants as well. The HMA Council has approved a Building Management Committee recommendation to hire a parking lot attendant on a part-time basis to ensure that adequate parking is available to HMA members or those people on HMA business.

Financially, the HMA building continues to be viable. Operational cash requirements are being fully met by lease rents received. As owned by HMA, the building provides occupancy costs to the HMA at an attractively low level, regardless of how one views occupancy costs. Last year, the payment on our Agreement of Sale was met by $28,000 from building operations and $72,000 from the Capital Advance Fund. No

1979 Budget
Hawaii Medical Association

EXPENSES	Estimated 1978	1978 Budget	1979 Budget
Salaries	339,000	376,000	418,900
Actuary	- 0 -	2,000	- 0 -
Auditing	6,000	4,500	5,000
Auto Expenses	7,500	6,500	8,000
Computer Reports	450	450	500
Council Expenses	4,700	4,500	4,500
Donation	1,000	1,000	1,000
Dues & Subscriptions	800	800	800
HAMPAC	1,000	1,000	1,000
Insurance & Bond	7,500	7,500	5,000
Lease-Office Equipment	3,500	4,200	3,600
Library Contribution	5,000	5,000	5,000
Legal & Professional	5,000	10,000	19,000
Meeting Expenses	16,000	15,000	15,000
Postage	5,000	5,200	4,000
President's Assistant	4,000	12,000	12,000
President's Contingency Fund	1,000	1,000	1,000
Repairs & Maintenance	3,000	2,000	2,500
Retirement Contribution	(14,000)	42,000	105,000
Stationery, Printing Supplies	10,000	20,000	8,000
Taxes (FICA, U/C, FUTA)	13,000	20,000	16,000
Telephone	5,000	5,000	5,000
Travel	10,000	13,500	12,000
Auxiliary	9,000	10,000	12,000
Committee Expenses	15,100	20,810	39,100
Journal	42,000	50,000	45,000
Annual Meeting	20,000	24,000	22,000
Roster	3,700	3,000	3,750
Continuing Medical Education	10,000	12,000	12,800
Fee Survey	- 0 -	20,000	- 0 -
Depreciation	- 0 -	- 0 -	- 0 -
Council Contingency	4,000	16,200	12,000
Education & Training	1,200	3,000	2,000
Interest—Equipment Loan	2,000	1,400	2,000
Miscellaneous	50	500	1,000
Promotion	500	- 0 -	- 0 -
Special Authorized Expense (HTR)	10,000	8,000	10,000
Special Council Contingency	1,500	40,000	40,000
Unbudgeted Expenses	900	- 0 -	- 0 -
Equipment Purchases	500	4,000	3,000
TOTAL EXPENSES	$554,900	$772,060	$857,450
NET GAIN (DEFICIT)	$193,950	($103,610)	($ 73,985)

Hawaii Medical Association
Schedule of Committee Expenses
1979

	Estimated 1978	1978 Budget	1979 Budget	
Legislative				
Legal Counsel	8,500	8,500	8,500	
Dinner & Entertainment	- 0 -	- 0 -	- 0 -	
Today's Health	- 0 -	300	300	
Miscellaneous	600	400	400	
Printing	- 0 -	1,500	1,500	
Consultant	- 0 -	- 0 -	- 0 -	
	9,100	10,700	10,700	
Public Affairs				
News Media Award	800	800	800	
Science Fair	200	200	200	
Tel-Med	6,000	6,000	6,500	
Salaries	- 0 -	- 0 -	- 0 -	(HMA)
Office Space	- 0 -	- 0 -	- 0 -	(HMA)
Meeting Expenses	- 0 -	- 0 -	- 0 -	(HMA)
Insurance, Legal Services	- 0 -	- 0 -	- 0 -	(HMA)
Office Equipment	- 0 -	- 0 -	- 0 -	(HMA)
Dues & Subscriptions	- 0 -	- 0 -	200	
Postage	- 0 -	- 0 -	3,200	
Stationery, Printing Supplies	- 0 -	- 0 -	5,000	
Travel	- 0 -	- 0 -	- 0 -	(HMA)
Miscellaneous	- 0 -	50	- 0 -	
Medical Student Affairs	- 0 -	- 0 -	500	
	7,000	7,050	16,400	
TV-Radio				
Video Cassettes	3,000	1,500	3,000	
Production Costs	- 0 -	1,500	- 0 -	
	3,000	3,000	3,000	
Sports Medicine				
Seminar	60	60	500	
Voluntary Effort (of Hospital Association)	2,500	- 0 -	2,500	
Medical, Moral, Legal Concerns	- 0 -	- 0 -	6,000	
TOTAL COMMITTEE EXPENSES	$21,660	$20,810	$39,100	

Hawaii Medical Association
Continuing Medical Education
Schedule of Income & Expenses

	Estimated 1978	1978 Budget	1979 Budget	
Income:				
Subsidies from Hospitals	1,000	1,000	1,500	
Expenses:				
Director (M.D., part-time)	- 0 -	- 0 -	8,000	
Secretarial Support	3,400	4,000	- 0 -	(HMA)
Consultation	- 0 -	1,000	- 0 -	
Publications Calendar	- 0 -	4,800	1,200	
HMA Award Printing	1,000	1,000	1,000	
Travel/Per diem (local)	400	400	400	
Travel/Per diem (mainland)	- 0 -	- 0 -	- 0 -	(HMA)
Stationery, Printing Supplies	1,000	2,500	1,000	
Postage	- 0 -	- 0 -	1,000	
Miscellaneous	200	200	200	
Office Space	- 0 -	- 0 -	- 0 -	(HMA)
Meeting Expenses	- 0 -	- 0 -	- 0 -	(HMA)
Insurance, Legal Services	- 0 -	- 0 -	- 0 -	(HMA)
Office Equipment	- 0 -	- 0 -	- 0 -	(HMA)
Dues & Subscriptions	- 0 -	- 0 -	- 0 -	(HMA)
TOTAL EXPENSES	$6,000	$13,900	$12,800	
NET INCREASE (DECREASE)	($5,000)	($12,900)	($11,300)	

monies came from HMA operations. If the Capital Fund contribution is considered part of occupancy costs, then it costs HMA 79 cents per square foot per month for its 7,577 square feet of space. If the Capital Fund contribution is considered equity buildup and not occupancy costs, then HMA's occupancy costs for its space is *zero*. It is interesting to note that when one considers contribution for shared space by two federal projects, the picture shows that HMA is being PAID 49 cents per square foot per month to occupy its space!

Lease negotiations with several of our tenants, including a major one, during the past year have had successful conclusions. The rental rates negotiated will contribute significantly to the economic viability of our building.

Preparatory activities have been initiated regarding a refinancing of the current Agreement of Sale. However, many details must still be worked out before any of the alternatives for refinancing can be presented.

Recommendations:

(1) That the entire HMA membership be sent a report of HMA's experience of the building.
(2) That investigation continue into the alternatives for refinancing our Agreement of Sale.

MARION HANLON, M.D., M.P.H.

Legal Counsel

ACTION: Filed

This report covers the approximate 12-month period from October 1, 1977 through September 25, 1978, during which your legal counsel attended the 1977 Caucus of Oahu Delegates, the meetings of the House of Delegates, most Council meetings, and several Honolulu County Medical Society Governors' meetings. In addition, several attorneys in Rice, Lee & Wong handled administrative calls, correspondence, and consultation on matters for the Association as requested and required by your staff and officers.

Subjects on which we conferred included questions relating to further review of the Peer Review difficulties being experienced by some county societies; doing research and expressing opinions on the EMS and PSRO program questions; review of questions raised by the Anti-Trust Division of the State Attorney General's Office for both the Council and the Board of Governors; examination of relationships with the Board of Medical Examiners, with particular emphasis on one member; review of proposed bylaw amendments; attendance at a Workers' Compensation Public Hearing relating to medical fees; the termination of the Mabel Smyth Building troika; the purchase and incorporation of the Physicians' Exchange; disposition of a deceased doctor's records, and record retention generally; and general administrative questions including the crane over the building.

There has been and will continue to be on-going involvement by your legal counsel in the operational problems relating to leases and management of 320 Ward Avenue Building.

Your legal counsel has no recommendations, and budget matters have been discussed with the Executive Director, and are included in his budget recommendations.

V. THOMAS RICE

Mabel L. Smyth Memorial Building Board

ACTION: Filed

The following individuals represented the Hawaii Medical Association on the Mabel L. Smyth Memorial Building Board of Management for the year 1977-1978:

Dr. Elmer C. Johnson
Dr. Grover Batten
Dr. Walter W. Y. Chang — Alternate

The following individuals represented the Hawaii Nurses' Association on the Mabel L. Smyth Memorial Building Board of Management for the year 1977-1978:

Mrs. Rosie Chang
Mrs. Sandra Chung
Mrs. Althea Kamau — Alternate

The following individual represented Queen's Medical Center on the Mabel L. Smyth Memorial Building Board of Management for the year 1977-1978:

Mr. Lester Gamble — Chairman

Building: (Other Items)

1. In October 1977 the Board of Management voted to allocate the 18 parking spaces at Mabel Smyth Building in ratio to the occupancy of the building.
2. The Queen's Medical Center "Cardio Pulmonary Resuscitation Center" moved into the second floor of the building in October 1977. Queen's Medical Center underwrote the cost to renovate the area occupied.
3. The Board of Management engaged Oberhausen and Associates, Electrical Engineers, to prepare a report on the condition of the electrical system of Mabel Smyth Building. The report detailed the deficiencies, inadequacies, hazards and violations of the Electrical Code of Hawaii. The estimated cost to correct the Code deficiencies and renovate the entire system was $55,000.00.
4. In February 1978 the Board of Management, at a Special Meeting, reviewed the possibilities of terminating the "Tripartite Agreement." The Agreement, signed in October 1939, provided for operation of the Mabel L. Smyth Memorial Building Fund by Queen's Medical Center, the Hawaii Nurses' Association and the Hawaii Medical Association. The Hawaii Nurses' Association had expressed interest in terminating the "Agreement" in January 1978.
5. The recessed meeting of February was resumed in April 1978. The Board of Management unanimously agreed to the terms of the legal document, prepared by the Hawaii Medical Association's legal counsel. The Board of Management of the Mabel L. Smyth Memorial Building Fund ceased to function as of April 21, 1978. The property became the sole responsibility of the Queen's Medical Center on that date.

Nurses & Physicians Exchange:

1. Pursuant to the terms for terminating the "Tripartite Agreement," the Honolulu County Medical Society acquired the Nurses and Physicians Exchange for one dollar.
2. The Exchange was incorporated July 1, 1978 under the name of "Physicians Exchange of Honolulu, Inc." The Board of Directors of the new corporation consists of nine physicians of the Honolulu County Medical Society.
3. The termination of the "Tripartite Agreement" provided for all fiscal assets of the Mabel L. Smyth Memorial Building Fund be transferred to the Exchange.

Motorola Radios:

1. Voice receiving radio subscriptions have increased from 304 in 1977 to 346 in 1978, representing a 13.8% increase.
2. Yearly radio messages have increased from 44,206 in 1977 to 69,234 or a 56.6% increase in 1978.

Activity Reports:

1. A total of 514,077 telephone messages were processed during the year, representing an increase of 26.2%.

Membership:	**1977**	**1978**
Physicians	426	449
Registered Nurses	51	34
Licensed Practical Nurses	16	10

ELMER C. JOHNSON, M.D.

Community Research Bureau

ACTION: Filed

The Community Research Bureau continues to operate as a fiscal agent for funds designated for charitable, scientific, literary, or educational purposes. During 1978, the Community Research Bureau has handled funds for the HMA-Emergency Medical Services program and, just recently, the funds from the Hawaii Chamber of Commerce for public health education television productions of "Health Conversations," an HMA activity. Current financial statements for these programs are on file in the HMA office. Reports on the activities of each of these programs are included separately in these proceedings.

Your Community Research Bureau feels that it does offer a very necessary and important service on behalf of the HMA members and the public and should continue in its present role. Otherwise, the Bureau has no recommendations.

O. D. PINKERTON, M.D.

Emergency Medical Services (EMS)

ACTION: Filed. The budget request for interim funding and legal expenses were approved for inclusion in the HMA budget.

I. The Oahu Emergency Medical Services Program Status Summary of HMA-EMS, as of July 1, 1978

During the past four years, the City & County of Honolulu and the Hawaii Medical Association (HMA) have received joint funding from the U.S. Emergency Medical Services Systems (EMSS) Act of 1973 (as amended by the Emergency Medical Services Amendments of 1976) to develop basic and advanced life support systems (BLS and ALS) for the Island of Oahu. The 15 mandatory EMSS-legislated components of the EMSS Act were implemented, as developed for Oahu, and assisted in the development of Oahu ALS capabilities. The Oahu ALS system is still not complete, nor is the entire State of Hawaii EMS system. In 1977-1978, the HMA-EMS Program and the HMA were very involved with the State of Hawaii Legislature in the legislative development of a statewide EMS Act for Hawaii (Act 148), as necessary to advance and complete EMS activities, BLS and ALS, statewide.

II. Status Summary of HMA-EMS Executive Board Meetings for the Period July 1, 1977—June 30, 1978

The HMA-EMS Executive Board met the fourth Tuesday of every month during the grant year and discussed major programmatic activities and provided overall policy direction to the program. The membership of the board was as follows: 5 voting members (3 members representing the Hawaii Medical Association; 1 member representing the State Department of Health and 1 member representing the Hawaii Hospital Association). In addition, there were several non-voting members in attendance at the meetings. The HMA-EMS Executive Board reported directly to the Hawaii Medical Association's Council. Pertinent agenda items discussed over the past year included:

- Plans For EMS Presentations at October, 1977 HMA Annual Meeting
- EMS Grant Extension
- Approval of V.A. Benefits for EMT and MICT Trainees Retroactive to January 31, 1977
- EMS Physician Consultants
- EMS Administrative Development Consultant To Be Hired By EMS
- Followup on Medications Book
- A Mechanism For The Non-Practicing MICT To Re-Enter The Field Of Prehospital Emergency Medicine
- 1977 911 Statistical Survey
- EMT National Registry Proposal For Neighbor Island EMTs
- Chamber of Commerce Proposal For Public Service Announcements
- Advanced Life Support Manual For Emergency Physicians
- HMA-EMS Proposed Legislation
- Massive Lay Public CPR Training Costs
- Oahu EMS Training Projections, 1978-1979
- Oahu MEDICOM Policy Statement
- Indepth Review of EMT, MICT-A, and MICT Courses by Physician Consultants
- Review of Radio PSAs
- Policy on Charging of Tuition
- Combining of EMT and MICT-Assistant Courses—Review and Approval of Proposal
- EMT and MICT Selection Criteria
- Addendum to MICT Standing Orders
- Ambulance Technician Trainee Selection Committee
- College Accreditation of Certain HMA-EMS Courses
- Lay Public Brochure
- Acceptance of Categorization
- Release of Funds to EMS from State Department of Health
- EMT, MICT-Assistant and MICT Continuing Education Requirements
- Revision to Chapter 48 Ambulance Rules and Regulations
- Abstracts and Papers Presented at Seattle EMS Meeting

III. HMA-EMS Program's Schedule of Activities to be Accomplished During the Period July 1, 1978—June 30, 1979

The HMA-EMS Program received a grant-in-aid from the State of Hawaii Legislature, totaling $687,000.00 for the HMA-EMS Program activities during July 1, 1978—June 30, 1979. Projected activities include:

- train emergency medical care personnel, all levels
- analyze hospital categorization, particularly for high risk patients
- expand EMS research—quality control, high risk categories, emergency interventive techniques
- re-evaluate EMS research data collection mechanisms
- continue public information and education
- re-review role of lay public CPR
- project program activities for future
- quantitate effectiveness of continuing education programs for emergency medical care personnel
- implement Medical Advisory Committee, EMS Physician Consultants, and trainee pre-exam activities, a new.

IV. Persons Trained in Hawaii Medical Association Emergency Medical Services Program (HMA-EMSP) Training Programs from 1/1/72—6/30/78: Cumulative State Totals, Oahu Totals, Neighbor Island Totals. See Table page 395.

Budget Request:

MICT Graduations	$ 1,200.00/year
Interim Financial Support for EMS	40,000.00 (FY 1980)
Legal Fees	10,000.00

LIVINGSTON M.F. WONG, M.D.

Additional References:

Chinn HYK: Emergency Medical Services—Hawaii, HAWAII MEDICAL JOURNAL 32:240, 1973.

Chinn HYK: Emergency Medical Services Program, HAWAII MEDICAL JOURNAL 33:477-479, 1974.

Sims JK, Akina S, Dods V, Wong LMF: The Emergency Medical Services Program of Hawaii. Part II. Emergency Medical Technician (E.M.T.) Training of Hawaii's Ambulance and Rescue Personnel. HAWAII MEDICAL JOURNAL 35:227-232, 1976.

Dang W: Emergency Medical Services, HAWAII MEDICAL JOURNAL 34:439, 1975.

Sia CCJ: The Oahu Emergency Medical Services Program, HAWAII MEDICAL JOURNAL 35:403-405, 1976.

Sims JK, Wright LM, Gavin JA, et al: The Emergency

Medical Services Program of Hawaii—I. General Overview, Hawaii Medical Journal 35:49-51, 1976.

Sims JK, Dang WWL: Five-Year Emergency Medical Services Training Update for January 1, 1972—January 1, 1977 and Emergency Personnel Continuing Medical Education Update Effective July 1, 1977. Hawaii Medical Journal 37:171-173, 1978.

Sims JK, Pozzi R, Wong LMF, et al: The Emergency Medical Services Program of Hawaii, Part III: The Hawaii Medical Association's Training of Mobile Intensive Care Technicians (MICTs) As Pre-Hospital Paramedics. Hawaii Medical Journal 37:203-208, 1978.

Persons Trained In Hawaii Medical Association—Emergency Medical Services Program (HMA-EMSP) Training Programs From 1/1/72 - 7/1/78: State Totals, Oahu Totals, Neighbor Island Totals Compiled July 21, 1978 (by J.K. Sims, M.D.)

	B	C	D	E	# Trained for Oahu Versus Neighbor Islands (Breakdown of Column D)						
HMA-EMSP TRAINING PROGRAM	Course Length (in hours)	Date First Course Offered	Cumulative Total # Trainees Passing	Cumulative Total # Trainees & % Fail/Drop /Incomplete	Cumulative Total # Trainees Oahu # Pass	%	Total # Trainees Neighbor Island Cum. # Pass	%	Total # Trainees Out of State Cum. # Pass	%	Cumulative No. of HMA-EMSP Classes Given
Lay Person Cardiopulmonary Resuscitation (CPR)[1]	12-16	Summer '75	5	0	5	100%	—	—	—	—	2
Lay First Responder Course[1]	40	Summer '75	2	0	2	100%	—	—	—	—	both took a LG FR class
Police First Responder (F.R.)[2] CPR BCLS 1-2-3-4	12	4/75	125 (12%)	0	125	100%	—	—10	—	—	—
First Responder	8-40		130 (12%)	2	130	100%					
Firefighter First Responder[3] CPR	12	12/74	959 (99%)	0	959	100%	—	—10	—	—	
40 hr. First Responder	40		555 (59%)	98	555	100%	—	—	—	—	—
Lifeguard (Ocean) First Responder[3] BLS CPR	12	11/74	78	0	78	100%	—	—10	—	—	
40 hr. First Responder	40		127	0	127	100%	—	—	—	—	—
Emergency Medical Technician—Ambulance (EMT-A)[4]	400	11/71	310	30 (9%)	229	74%	81	26%	—	—	27
Mobile Intensive Care Technician Assistant[5]	320	7/76	33	12 (27%)	33	100%	—	—10	—	—	5
Mobile Intensive Care Technician (Paramedic)[5,6]	1215	9/72	129	66 (34%)	99[6]	77%[6]	30[6]	23%[6]	—	—	14
Emergency Room Registered Nurse[7]	120	4/73	188	0	175	93%	13[11]	7%	—	—	16
Intensive Care Unit Registered Nurse[7] (CCU/ICU/RR/SICU)	120	9/75	120	1	116	97%	4	3%	—	—	13
ER/ICU Registered Nurse BCLS/ACLS BCLS 1-2-3-4	8	10/77	53	1 (2%)	48	100%	5	83%	—	—	4
ACLS	14	11/77	75	6 (7%)	68	91%	6	8%	1	1%	4
Emergency Room Physician (Variable)[8]											
• Hawaii ER Physician Seminars	variable	7/73	N.A.	N.A.	Av. 34 (91%) Total Oahu Attending Cumulative—495		Av. 2.5 (9%) Total N.I. Attending Cumulative—35		—	—	7
• BCLS 1-2-3-4-5	8	1/77	50	3 (6%)	46	96%	2	4%	2	4%	5
• ACLS	14	2/77	93	5 (5%)	85	91%	5	5%	3	3%	8
• ATLS Trauma Lab	5	9/77	37	0 (0%)	27	73%	9	24%	1	3%	4

Hawaii Resident Population (excluding military, 1975)[9] total *864,900;* Oahu *704,500* = 82%; N.I. *160,400* = 18%

All figures and percentages compiled from HMA-EMSP Training Staff Statistics (excepting the Hawaii Resident Population Figures)

Legend For 1/1/72—6/30/78 Training Program Table

[1]not a formal training program of HMA-EMSP for any grant period

[2]training is variable, depending on time made available by the Honolulu Police Department (HPD): CPR is included (12 hrs. of Basic Life Support, CPR); Crash Injury Management Guidelines are used partially; HPD = 1050 field police (1472 total includes administrative personnel)

[3]program approved by OSHA State of Hawaii; includes American Heart Association BLS CPR 1-2-3-4 Certification; Lifeguard Service (120 total, with 60 full time); Honolulu Fire Department (944 total personnel with 898 field)

[4]approved by National Registry of Emergency Medical Technicians; training described: Hawaii Medical Journal 35:227-232, 1976

[5]approved, Board of Medical Examiners, State of Hawaii

[6]approved, National Registry of Emergency Medical Technicians, as an EMT-Paramedic Training Course. Includes HMA-EMS-trained MICT's as: HPD policeman-Oahu (1); C&C Honolulu Amb. Service Administrators—Oahu (2); SDOH EMSS Administrator—N.I. (1); SDOH EMSS Instructors—N.I. (3); transfers to U.S. mainland N.I. and Oahu

[7]approved, Hawaii Nurses Association; BCLS and ACLS are national certification courses of the American Heart Association

[8]excepting Hawaii Emergency Physician Seminars (HEPS) 1, 2, and 3, all remaining activities approved for Category I Physician CME Credits from A.M.A. and A.C.E.P.; 7 HEP Seminars, 5 Basic Life Support CPR Certification Course, 8 Advanced Cardiac Life Support Certification Courses; 7 HEPS (495 Oahu M.D. visits, 35 N.I. M.D. visits); BCLS = Basic Cardiac Life Support CPR Certification; ACLS = Advanced Cardiac Life Support Certification; BCLS and ACLS are national certification courses of the American Heart Association

[9]from Department of Planning and Economic Development; *The Population of Hawaii 1958-2025,* Statistical Report #114, Table A-2 (Total Resident Population) p. 10, State of Hawaii

[10]not offered by HMA-EMSP to N.I. personnel since grants were restricted to Oahu

[11]seven (7) of these Neighbor Island R.N.'s were trained to be instructors for the ER R.N. Course for each Neighbor Island

Hawaii Foundation For Medical Care

ACTION: Approved

The Hawaii Foundation for Medical Care, a subsidiary of the Hawaii Medical Association, has remained inactive during 1978. The House of Delegates, last year, adopted the posture that while the Foundation not commit itself to Health Maintenance Organization development, that the Foundation continue as an incorporated subsidiary under HMA. Many new issues and modifications of existing issues have arisen regarding health care costs and regarding accessibility of health care. The HMA Council has taken these issues up during the course of the year. While nothing definite has been determined, it would be wise to continue the Foundation as a viable corporation under the HMA during the next year as a possible vehicle to accomplish some of the potential activities of HMA.

Recommendations:

(1) That the Hawaii Foundation for Medical Care continue as a corporation.
(2) That the HMA House of Delegates request the HMA Council during the coming year to review the circumstances of the Hawaii Foundation for Medical Care and report its finding and any recommendations to the 1979 HMA House of Delegates.

WINFRED Y. LEE, M.D.

HMA Auxiliary President

ACTION: Filed

The Hawaii Medical Association Auxiliary has always been traditionally a center for bettering communication among all four county auxiliaries, encouraging counties to promote their legislative and health-oriented programs, providing leadership training, developing good public relations for doctors and assisting the Hawaii Medical Association when requested.

In our present inflationary economy, we find it impossible to fulfill these functions on our present income from the Hawaii Medical Association of $4.00 dues per HMA member.

In the last ten years, we have not received any increase in HMA Auxiliary dues. Currently, we receive $4.00 per member based on an approximate membership of 700, giving a total income of $2800.00 a year. Our 1977 operating budget was $5387.31. We had to withdraw from our Savings the difference of about $2500.00. Our 1978 operating budget is about $5600.00. We will need to use up most of our Savings to balance our budget; thus, leaving about $400.00 in Savings at the end of 1978. We will not be able to function at our present level in 1979, unless we have an increase of our dues.

The finance Committee of the HMA Auxiliary strongly recommends that we have an increase of our dues from $4.00 to $8.00 per HMA member commencing the fiscal year 1979.

MRS. HENRY L. YIM

Executive Director

ACTION: Approved

Your Hawaii Medical Association has had another extremely busy year with those problems, challenges, and opportunities that seem to be given to a responsible profession when something really needs to be accomplished. These critical issues that your HMA dealt with are ably presented in your President's report and do not need to be repeated. I believe that you members need to know that your staff at HMA has performed admirably under mostly trying circumstances during this past year, as in years before. There has been minimal griping and a great desire by staff to do their best on behalf of physicians. For this, I wish to commend the staff.

The more important issues I wish to address in this, my second report as your Executive Director, deal with communication and with responsibility. Communication, everyone agrees, is necessary; and no organization can have too much of it. But somewhere along the way, communication between physicians seems to be limited to only medical matters. If you, as members of the HMA, sincerely believe that organized medicine in general and the HMA and its component societies in particular are important in representing the physician in the myriad of issues and activities in this community, then why does HMA membership represent only a slight majority of the practicing physicians in our State? The staff at HMA can contribute much to letting physicians know what organized medicine and HMA is all about. The final selling belongs in your arena, doctor! No one else can communicate why organized medicine and HMA is so necessary to the medical profession. If you physicians do not sell it to other physicians, then maybe organized medicine and HMA are NOT necessary. It is up to you. Your HMA staff can help, and help they will, in any way possible. But you need to let us know what YOU need so you can communicate your message for HMA.

Responsibility for determining what direction YOUR medical association takes belongs to you. This responsibility also entails that bothersome but important aspect of financing those programs and activities that you feel are necessary and important to the medical profession. The report of the Building Committee demonstrates a wise move on the part of the HMA leadership when our building was purchased. We all can look to that time when your building, unencumbered by a mortgage, can begin to produce that revenue to enable your HMA to expand existing programs and activities or initiate new ones without costing each member an arm and a leg. Until such time, however, problems and challenges remain with us. Your HMA leadership has done a remarkable job in bringing your HMA to its current sound financial position. Many different activities, especially federally funded programs, have helped in this financial development. But federal programs do not continue forever, nor should they. But recognition of this fact must not only be made but also planned for. I believe that you HMA members want to know, and need to know, what each of the activities of the HMA is costing, and office functions have been broken down into areas of activities with attempts to allocate actual costs to each area. This is still in the initial stages of development. The startling situation that has developed out of this attempt is the apparent understaffing of the HMA to meet those existing programs and activities already committed to. This report is not a plea for more dues for more staff; it is a plea for HMA, leadership and members in general, to begin to look toward some serious and continuing planning for five to ten years ahead. This attempt at planning was begun in 1977 with the Honolulu County Medical Society general membership planning session and the HMA Leadership Conference in 1977. This is a start, but it must not be allowed to fall by the wayside. Planning is an important part of organizational survival and growth, and HMA and its component societies must recognize this need. HMA activities alone account for a budget of over a half-million dollars; HMA activities and related organizations and programs amount to almost 3 million dollars in budgetary considerations. Planning is a responsibility and a must!

Any organization is only as strong as the members it represents as well as the intensity of the participation of its members. You members have participated and participated well. Your HMA needs more members that can truly participate, and planning by members is an important key to financial responsibility and growth. I only hope that I have been able to relay my message to you.

Recommendations:

1. The HMA undertake a program to encourage and assist county medical societies in membership recruitment materials and programs.
2. The HMA commit itself, and encourage county medical societies to undertake regular planning activities for their respective organizations.

JONATHAN R. WON

Resolution No. 3

ACTION: Adopted as amended.

WHEREAS, it is highly desirable and/or necessary, from time to time, to have the HMA receive input from non-member health-oriented community individuals; and

WHEREAS, it may be necessary, in some instances, where federal funds are involved in health care projects of the HMA, that the health community outside of the HMA be involved; and

WHEREAS, the current bylaws of the HMA restrict the voting members of the HMA committees and commissions to only active, dues paying, active, dues waived, or special, dues paying members of the HMA, now, therefore, be it

RESOLVED, that the HMA bylaws be amended to state, in

effect, that if the HMA Council determines, from time to time, that input from the lay community or from non-member physicians is desirable or necessary, that the HMA Council may appoint or elect or cause to be appointed or elected, non-members of the HMA as voting/non-voting members, but not chairman of any HMA committees, commission or board so long as a majority of the voting members of any and all HMA committees, commissions, and boards consist of HMA members. The Council in so appointing such individuals shall designate whether that individual will be a voting or non-voting member.

HERBERT Y. H. CHINN, M.D.

Resolution No. 7

ACTION: Not Adopted

Re: Building Fund

WHEREAS, two years have passed since the Hawaii Medical Association moved into its new headquarters at 320 Ward Avenue, and

WHEREAS, several of the members who elected the Building Fund payment option of $100 per year for 10 years have expressed the desire to make payments to the Fund at the same time they pay dues, and

WHEREAS, including the billing for the Fund on the dues statements will result in savings in postage, paper, and time, now therefore be it

Resolved, that the dues statements for 1979 and thereafter include a Building Fund item for the yearly minimum payment of $100, and therefore be it further

Resolved, that the delinquency date for Building Fund payments remain December 31 of each year to allow those who elected the option of monthly payments to continue to do so.

WILLIAM W. L. DANG, M.D.

Resolution No. 8

ACTION: This resolution was withdrawn.

HAMPAC

ACTION: Approved

The activities for HAMPAC during 1978 have been primarily directed towards membership, physician education, and candidate support. We continued the physician political education workshop concept and held a very successful one on February 14, 1978 at the Ala Moana Hotel. Approximately 60 physicians and spouses attended as well as the following speakers: Rex E. Kenyon, M.D., AMPAC Chairman; Peter Lauer, AMPAC Staff; Paul M. Newman, Political Consultant; U. S. Senator Sparky Matsunaga, Rep. Faith Evans, Senator Dennis O'Connor, Rep. Neil Abercrombie, and Rep. Richard Garcia.

The membership drive continued on the concept of eyeball to eyeball contact. The membership as of August 31, 1978 showed a total membership of 208 of which there were 19 sustaining members and 14 spouse memberships. This is a drop from the previous year of 310 total members, 14 sustaining members and 32 spouse members. The Hawaii delegation was again recognized at the AMA Annual Meeting and presented a special award for having every member of the delegation a sustaining member of AMPAC.

Plans for the coming year include another political education workshop in January or February. We also hope to increase participation in HAMPAC and hope that more physicians and spouses will become directly involved in the political arena.

Budget Request:

Educational fund—$1,000.

LEONARD R. HOWARD, M.D.

Nominating

ACTION: Approved

The Nominating Committee met to receive nominations for officers of the Hawaii Medical Association. The following slate of nominees was submitted to be elected by the House of Delegates:

President-Elect Douglas B. Bell II
Secretary Neal Winn, Calvin Kam
Alternate AMA Delegate William Iaconetti
Councillor from Kauai Thatcher Magoun
Councillors from Honolulu Nadine Bruce
Thomas Cahill
Bernard Fong
Philip McNamee

All nominees have been contacted and have agreed to serve if elected.

HERBERT Y. H. CHINN, M.D.

Election

ACTION: The report of the Nominating Committee was presented and the President called for nominations from the floor. There were no further nominations. Ballots were distributed and Drs. Felix Lafferty and Gary Salenger were appointed tellers. The following were elected:

President-Elect Douglas B. Bell II
Secretary Neal Winn
Alternate AMA Delegate William Iaconetti
Councillor from Kauai Thatcher Magoun
Councillors from Honolulu Nadine Bruce
Thomas Cahill
Bernard Fong
Philip McNamee

The Nominating Committee was elected as follows: Felix Lafferty, Herbert Chinn, Andrew Morgan, Calvin Sia, William Dang, Sakae Uehara (Maui), Rex Couch (Kauai), Arch Wigle (Hawaii).

New Business

ACTION: The House of Delegates voted to commend Dr. Hanlon and give him a standing ovation for his outstanding leadership as HMA President.

The meeting adjourned at 5:30 p.m.

DOUGLAS B. BELL II, M.D.
Secretary

Awards

Medical Reporting Awards
Tom McWilliams—KHON-TV 2
Kathy Titchen—Star Bulletin

A. H. Robins Award
Morton Berk, M.D.

Sportsmen's Awards

Tennis:
Singles champion—Benjamin Chang
Doubles champions—Gerard Dericks & Benjamin Chang

Golf:
President's Trophy—Neal Winn
Robert Miyamoto Perpetual Trophy—Donald Maruyama
John Felix Perpetual Trophy—Neal Winn
George Mills Perpetual Trophy for Pharmaceutical Representatives—Bill Lawrence

Table Tennis:
Singles champion—John Spangler
Doubles champions—John Spangler and Philip McNamee

Just what do you get for your AMA dues?

You get a package of personal and professional benefits and services that are the most extensive of any professional organization.

You get group insurance programs that provide coverage at far lower costs than individual coverage. They include: Group Life Insurance, Excess Major Medical, Disability Income Insurance, Supplemental "In Hospital" Insurance, Accidental Death and Dismemberment Plan, and Office Overhead Insurance.

You get publications to keep you abreast of medical and health developments: *JAMA*, *American Medical News*, and one of nine specialty journals.

There's the AMA Members Retirement Plan. Professional practice management information and guides. Authoritative legal information. Continuing medical education. The nation's largest physician placement service. The research resources of one of the nation's greatest medical libraries.

These are just a few of the broad range of benefits you get for your dues. Even more important, you get a strong and effective spokesman to represent you, your interests, and your views.





Join us.
We can do much more together.

Dept. of Membership Development
American Medical Association
535 N. Dearborn St./Chicago, IL 60610

Please send me more information on the AMA and AMA membership.

Name _____

Address _____

City/State/Zip _____

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m. & 3rd Tues. w/ Maui Mem. Hsp.

John A. Burns School of Medicine

1. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Rm. 618, University Tower, 1356 Lusitana St. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 548-2810.
2. U.H. Cardiology Grnd. Rnds., 1st & 3rd Tuesday, 5:30 p.m. Rm. 506 Univ. Tower, Queen's.
3. UH Grand Rnds-Ob/Gyn, Wed. 7:30-8:30 a.m. Kapiolani Hsp. Aud.
4. UH Perinatal Conf., Thurs. 3:30-4:30 p.m. Kapiolani Hsp. Rm. 815.
5. UH Seminar, 2:30-3:30 p.m. Kapiolani Hsp. Rm. 826. Fridays, 1st-Pathology; 2nd-Perinatology; 4th-Journal Club.
6. UH Conf., Friday, 3:30-4:40 p.m. Kapiolani Rm. 826.
7. Psychiatry Grand Rounds, 1½ hours credit, Friday 8:00 a.m.-9:30 a.m. University Tower, 6th Floor, 1356 Lusitana Street. Contact: Dr. McDermott at 548-3420.
8. Psychiatry Case Conference, 1½ hours credit, Tuesdays 10:00-11:30 a.m. University Tower, 4th Floor, 1356 Lusitana Street. Contact Dr. McDermott at 548-3420 or Dr. Wen-Shing Tseng.
9. University Medical School Grand Rounds, 3rd Thursday, 4:30-6:00 p.m.

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, 1st Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, 2nd Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, 3rd Friday, 12:30-1:30 p.m.
5. C.P.C., 4th Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1977, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. 3rd Tues. 12:30-2:00 p.m.

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology-Neurosurgery Conference, as designated

Kapiolani Maternity Hospital

1. Tuesday Conference, 1:00-2:00 p.m. Kapiolani Hsp. Aud.
 1st—Didactic Presentation
 2nd—Perinatal-Neonatal Topics
 3rd—Obstetrics Topics
 4th—Gyn Topics
2. Neonatal Grand Rnds., Friday 8:00-9:00 a.m. Kapiolani Hsp. Nursery.
3. Tumor Board-Oncology Conf., 1st & 3rd Friday, 1:00-2:00 p.m. Kapiolani Hsp. Aud.

Kuakini Medical Center

1. Visiting Professor Program
2. G.I. Conference, 4th Tuesday, 8:00-9:00 a.m.
3. Nephrology Conference, 4th Wednesday, every month, 8:00-9:00 a.m.
4. Oncology Conference, every Thursday, 7:30-8:30 a.m.
5. Surgical Conference, 1st, 2nd, and 3rd Friday, 1:00-2:00 p.m.
6. Surgical Mortality and Morbidity Conference, 4th Friday, 1:00-2:00 p.m.
7. Opthalmology Departmental Meeting, 2nd Tuesday, every month, 1:00-2:00 p.m.
8. Medical Mortality & Morbidity Conference, 3rd Tuesday, every month, 1:00-2:00 p.m.

(Contact CME Dept.-Kuakini for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room

St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. (1st) 7:00 a.m.
3. Dept. of Med. Monthly Mtg. 2nd Tues. ea mnth. 7:30 a.m. UH 4 Classroom.
4. SFH-UH Surgical Grnd. Rnds. Fridays (except 4th), 7:30-8:30 a.m. UH 4 Classroom.
5. SFH-UH Surg. Mortality & Morbidity Conf. 4th Fri., 7:30-8:30 a.m. UH 4 Classroom.
6. SFH-UH Surg. Sat. Teaching Rnds. (except 4th) 7:30-8:30 a.m. UH 4 Classroom.
7. SFH-UH Hematology Conf., 4th Thurs. ea. mnth. 12:30-1:30 p.m. UH 4 Classroom.
8. SFH-UH Renal Conf. 1st Monday ea. mnth. 7:30-8:30 a.m. UH 4 Classroom.
9. Tumor Conf., ea. Monday, 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Anesthesia Conference meets the 2nd Tuesday of the month, from 7:00-8:00 p.m. in the Doctor's Dining Room.
2. Cardiac Surgery Meeting meets the 2nd Tuesday of the month, from 4:30-5:30 p.m. in the Doctor's Dining Room.
3. Friday Noon Conference meets weekly, from 12:30-1:30 p.m., in the Doctor's Dining Room.
4. Medical Grand Rounds meets the 1st Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.
5. Orthopedic Conference meets quarterly, from 7:30-9:00 p.m., in the Doctor's Dining Room.

6. Quarterly Professional Meeting meets the 4th Monday of the month, from 7:30-8:30 p.m., in the Doctor's Dining Room.
7. Surgical Mortality and Morbidity meets the 4th Thursday of the month, from 7:00-8:00 a.m., in the Doctor's Dining Room.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:00 p.m. & 3rd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

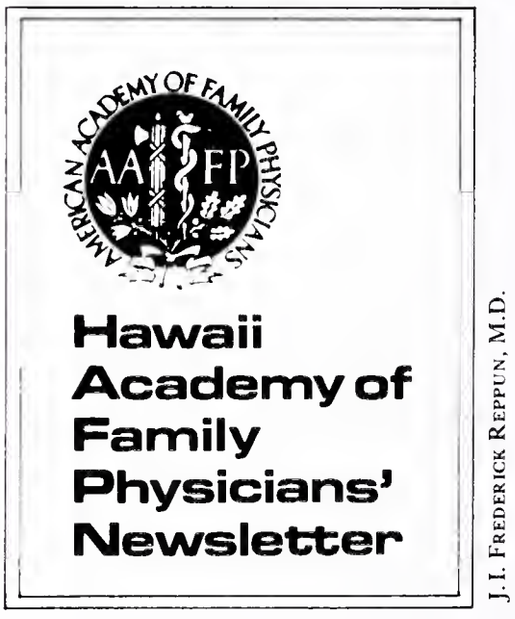
Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Local Hospitals, Honolulu
Type: I, 1 hr./day, 1 day/mo. from 12 mos.
Fee: None Methods: AV, O, Pan
Dates: All yr., 12 hrs. instruction

SPECIAL EVENTS

Dec. 6-7-8-9, 1978	Am. Med. Joggers Assoc. 16 hours Cat. 1. Contact: Kent Davenport, M.D. or Honolulu Marathon Assoc., P.O. Box 27244, Chinatown Station Honolulu, 96827.
Jan. 4-6, 1979	Maternal & Fetal Med. Am. Coll of Obstetricians & Gyns., 1 E Wacker Dr., Chicago 60601. At: Hyatt Regency, Honolulu. 2½ days, 16 hrs.
Jan. 8-12, 1979	Echocardiography: A Review of Current Concepts & Techniques. Am. Coll of Cardiology, 9111 Old Georgetown Rd., Bethesda, MD 20014. Cosponsor-U of H John A. Burns Schl of Med., The Honolulu Med. Group Research Found. Held at Wailea Beach Htl., Wailea, Maui. 5 days, 20 hrs.
Jan. 15-17, 1979	Urology for Specialists, Univ. of Ore Hlth Sciences Ctr., Div of Cont Med Educ, 3181 SW Sam Jackson Pk. Rd., Portland, OR 97201. Held at: King Kamehameha Htl., Kailua-Kona, HI. 3 days, 16½ hrs.
Jan. 20-27, 1979	Adv. in Nephrology, USC Sch of Med., Div. of Postgrad., 2025 Zonal Ave. LA, CA 90033. Held: Intercontinental Htl, Maui. 5 days, 30 hrs.
Jan. 22-28, 1979	4th Annual HI Hosp. Med. Staff Conf. Estes Park Inst., Box 400, Englewood, CO 80151. Cosponsor: Queen's Med. Cntr. Held at Kauai Surf Resort, Kalapaki Beach, Kauai 96766. 5 days, 30 hrs.
Feb. 1979	Workland Recording Workshops, Coll of Am. Pathologists, 7400 N. Skokie, IL 60077. Held at Sheraton Waikiki, Honolulu. 15 hrs.
Feb. 6-9, 1979	Perinatal Med. USC Sch. of Med., Div. of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Royal Lahaina, Maui. 5 days, 19¼ hrs.
Feb. 19-22, 1979	Mid-Winter Traveling Med. Educ. Course, Kansas City SW Clin. Soc., 2220 Holmes, KC, MO 64108. Cosponsor: U of MO-Kansas City Sch. of Med. Held at Maui Surf Htl., Maui. 4 days, 16 hrs.
Feb. 19-25, 1979	Financial Planning/Med & Dental Prac Management, Med Communications & Servs Assn. 1107 NE 45th, S 315, Seattle, WA 98105. Held at: Sheraton-Molokai, Box 1977, Kepuhi Beach, Maunaloa, Molokai.
Feb. 26-Mar. 2, 1979	Surg. Diag. & Therapy, The Phil Thorek Postgrad. Courses, 850 Irving Park Rd., Chicago 60613. Held at Maui. 5 days.
Mar. 6-10, 1979	U of H Sports Med. Course, Contact: HI Conf. Servs., Harold Brown, P.O. Box 25055 or (808) 377-6445, Honolulu 96825. Reg. Fee HI Residents $100. Cosponsor: AAFP. Held at Princess Kaiulani Htl. Waikiki, Honolulu. 5 days, 18 hrs.
Apr. 15-21, 1979	Current Concepts in OB/GYN, Mem. Hosp. Med. Ctr. of Long Beach-Women's Hosp. 2801 Atlantic Ave., Long Beach, CA 90801. Cosponsor: U of CA, Irvine Ctr. for Health Educ. Held at Kauai Surf Htl, Lihue, 06766. 3 days, 24 hrs.
Apr. 15-21, 1979	Diving Med. U of H Schl of Med. 1960 E-W Rd., Honolulu 96822. Held at King Kamehameha, Kailua-Kona, HI. 6 days.
Apr. 21-28, 1979	Emergency Med-1979 USC Sch. of Med. 2025 Zonal Ave. LA, CA 90033. Held at Royal Lahaina Htl., Maui. 5 days, 30 hrs.
Apr. 21-28, 1979	Diagnostic & Therapeutic Skills in Internal Med., USC Sch of Med., Div. of Postgrad., 2023 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.
Apr. May 18, 1979	Orthopedic Review, USC Sch of Med, Div of Postgrad., 2025 Zonal Ave., LA, CA 90033. Held at Mauna Kea Beach Htl, Kamuela. 5 days, 30 hrs.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 15, 1977 Supplement to JAMA or call the HMA Office.



NEW MEMBERS—Gary W. Crawford, UHSM '81, **Leo M. Crowley MD** as Active, **Richard Lee-Ching MD** 1975 grad of UHSM is with the St. Francis Primary Care Center, **Jim Marnie MD,** long-time GP and Surgeon in Honolulu has joined as an Active member and **Ed Underwood MD,** equally long-time GP on Maui has become an Active member. It is nice to have a mix of the new and the old join us!

DROPPED from membership—Bill Brownlee MD who moved to Colorado from TAMC a long time ago and has not been heard from.

NEWS of MEMBERS—Bob & Ruth Benson made themselves known as having attended the Scientific Session in San Francisco in September. So did **Juan**

Tomas Van Putten from TAMC; he received his Fellowship degree at the convocation. **Pat Dietrich** and **Glenn Stahl** both were voted into Active status at the November Council meeting of HAFP. **Bob Bell** has joined the North Shore Clinic in Kahuku.

ANNUAL MEETING—and dinner will be at the Ilikai Hotel on Saturday 27 January in 1979. New officers and councillors are to be elected and will be installed by AAFP President Jack Stelmach. A formal notification and slate will be issued to members soon. As of now, our new President will be **Dave Swanson** from TAMC; the Council, as nominating committee, has proposed: **Pat Dietrich** as Pres-elect, **James Tsuji** as Secretary, **Fred Reppun** as perennial treasurer, **Farrell** and **Lafferty** as delegates, **Dodge** and **Reppun** as alternates, **Cahill** and **Lafferty** as representatives to the Hon Cty Med Soc. Serving as Councillors through 1979 are **Dodge, Fitzharris** and **Hase;** through 1980 are **Jasinski, P. Walsh** and **Larry Wong.** Nominated for 3 years to serve through 1981 are **Lincoln Luke, Don Newman** and **Glenn Stahl.** A revision of the By-Laws will need a vote.

CME—THE most important for members of HAFP will be 11 hours of "P" credit to be available on 27 and 28 January 1979 in conjunction with our annual meeting. Noble Butler, Ph.D., Chief of Education, Family Institute of Chicago Center for Family Studies and Ass't Prof. of Clinical Psychiatry at Northwestern School of Medicine, will present a "*Mini-workshop in Family and Marital Therapy*" from 9:00 AM to Noon and from 1:30 PM to 4:30 PM each day at Mabel Smyth Auditorium. The registration fee for AAFP members will be $50, for all others $60 except for Residents and Students $25. Attendance will be limited, so sign up early with Jean Reppun, 47-410 Lulani St, Kaneohe 96744 (239-8383). Quick reminders of CME to come: 6-9 Feb 79 Crystal Mountain, Washington 14 "P", 21-24 Feb Tucson, Arizona 19 "P", 24 Feb-3 Mar Phil Thorek at Lahaina, Maui 20 "P", 9-13 April U of Washington and UH on Ob/Gyn 20 "P" and 23-26 May in Honolulu on Sports Medicine.



November 3, 1978
HMA CONFERENCE ROOM

PRESENT:
Drs. George Goto, Douglas Bell, Neal Winn, William Hindle, Marion Hanlon, Herbert Chinn, William Iaconetti, Patrick Walsh, Russell Stodd, Rex Couch, Nadine Bruce, Bernard Fong, Thomas Cahill, Leonard Howard, Alexander Roth, Felix Lafferty, Arch Wigle, Thatcher Magoun, George Mills, William Dang, Roy Kuboyama and Donald Char. Also present were Mr. Tom Rice, Mr. John Won, Mr. Andrew Saranchock, Mrs. Ceci Young, Mrs. Irene Wong, Mr. Les Ajifu and Mr. Ned Ontai.

GUESTS:
Dr. Thomas Hall and Dr. Kolonel from the Cancer Center of Hawaii.

MINUTES:
The minutes of the previous meeting were approved as circulated.

TREASURER'S REPORT:
The Council members briefly reviewed the Treasurer's Report for the period ending September 30, 1978.

ACTION:
It was voted to approve the financial statement for the period ending Sept. 30, 1978 subject to audit.

REPORTS OF THE COMMITTEES AND COMMISSIONS:

A. TUMOR REGISTRY: In the President's Report to the 1978 House of Delegates, Dr. Marion Hanlon recommended, and the House agreed, that the Council should reconsider their previous action (July 1977) approving the move of the Tumor Registry to the Cancer Center building on the Queen's Hospital grounds in view of a change in the relationship between the University and the Hawaii Medical Association. At the meeting Dr. Hall and Dr. Kolonel each discussed the reasons why they feel the Tumor Registry should be relocated. Their main concerns were improved data, efficiency in obtaining data and convenience in quick retrieval of data. Both felt that the registry is a vital component to the program as a whole. Council members discussed the credibility of the Cancer Center and the University in light of past statements made by the University and their grave concern for maintaining confidentiality of patient data so that the registry does not lose the confidence of the clinicians who provide the data for the registry. After a lengthy discussion, the following vote was taken:

ACTION:
It was voted to reverse the action taken by the Council on July 8, 1977 and NOT move the Tumor Registry to the new Cancer Center building.

B. CANCER COMMISSION: Since the Cancer Commission did not meet during 1978, there was some question as to whether the chairman should be replaced on the Commission. It was stated that each Pres. appoints the chairman at this time of the year. It was recommended that the current chairman remain as a member of the Cancer Commission.

C. SELF INSURANCE: Dr. Chin reported that the Self Insurance Committee is reviewing the credentials of the Medical Insurance Exchange of California. The committee instructed them to meet with the Insurance Commissioner here in Hawaii to see whether their program is restricted by any State laws governing new insurance programs.

D. BUILDING COMMITTEE:

1. Right of Entry Agreement: The Executive Director of the Hawaii Community Development

Authority, in a letter to HMA dated September 28, 1978, requested permission to enter the 320 Ward Avenue property, which is within the Kakaako Community Development District, for the purpose of gathering planning and surveying data. They enclosed a Right of Entry agreement which was reviewed by the Building Committee and legal counsel. They suggested that three areas by clarified before approval for entry is given: (1) It should be specified how much notice they will give HMA prior to entering the 320 Ward property; (2) where holes will be drilled on the property and how large these "borings" will be and (3) evidence of insurance against damage to 320 Ward Avenue property.

ACTION:

It was voted to execute the Right of Entry Agreement with the above modifications.

2. Roof Repair: The Building Committee obtained estimates from two roofing companies for re-roofing of 320 Ward Avenue. Oahu Roofing estimated $19,240 with Victor's Roofing estimating $19,530.

ACTION:

It was voted to approve the Building Committee's recommendation that Oahu Roofing do the re-roofing of 320 Ward as soon as possible.

3. Locations, Inc. Lease Negotations: Mr. Won reported that negotiations are continuing with Locations, Inc. for renewal of their lease. Three stipulations that Locations had on the renewal were (1) Permission to sub-let 2,000 square feet to another company at $1.05 per square foot; (2) permission to allow a sign in their window and (3) another five year option. Mr. Won has already stated that another five year option is unacceptable and has requested further information and specifics on the sign that they wish to post. Location's lease has been negotiated for 95$^{¢}$ sq. ft. for the first two years of the lease and $1.00 per sq. ft. for the last three years. Seventeen parking stalls are presently included in the lease arrangement.

ACTION:

It was voted to approve another five year lease with Locations, Inc. however, the difference between 95$^{¢}$ and $1.05 that Locations is charging to sub-let the 2,000 sq. ft. must be remitted back to HMA. Seventeen stalls will be included as part of the lease arrangement also.

E. HEALTH SERVICES AND CARE:

1. Voluntary Cost Containment Committee: Dr. Mills distributed a news release from the Voluntary Cost Containment Committee (VCCC) comparing hospital expenditures for the first two quarters of 76/77 and 77/78 which showed a decrease of 7.80 percentage points in the rate of inflation for the first two quarters. Dr. Mills also noted that Mr. Peck from the University of Hawaii School of Medicine has established a committee of representatives from local teaching hospitals who will be reviewing costs of training interns and residents and educating them as to how they can help contain medical costs. Dr. Marion Hanlon is chairman of the physician's committee to educate doctors in the community on cost containment measures they could undertake.

2. HMA Position on National Health Insurance Legislation: Dr. Mills stated that the AMA would like to know what the opinion of the HMA is on National Health Insurance. AMA feels that there should be a health insurance package in the 96th Congress. He stated that HB1818 and SB218 provide for basic health insurance, catastrophic health insurance plan, a health plan for women and children, health insurance for the unemployed and would encompass the Medicaid and Medicare program. He felt that HMA should support the concepts outlined in these bills.

ACTION:

It was voted that HMA, in principle, support the concepts embodied in HB 1818 and SB218.

3. AMA Newsletters and Legislative Roundup: Dr. Mills stated that AMA has agreed to provide HMA with 30 copies each month of the AMA Newsletter and the Legislative Roundup for distribution (by HMA) to the various officers and members of the Council.

4. Getting Medical Students Involved: Dr. Mills met with medical students at the University and reported that 86 students and 60 residents are direct members of the AMA. Only two students are presently members of HMA and HCMS. He felt that the county and state association should become more involved with the students and it was suggested that the students be apprised of the fact that HMA and HCMS dues are waived and encourage them to become members through their county and state associations. Mr. Won stated that he will check with AMA as to why they accepted student dues when they are supposed to join through their local state association.

F. EMS: Dr. Dang reported that HMA got the state grant in aid for the EMS program and the contract is being written up at the present time. Funds will be delayed until a contract is executed however, HMA will be reimbursed for funds spent prior to actual signing of the new contract. The House allowed

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$40,000 for interim funding of the EMS program and it was requested that the Council release these budgeted monies.

ACTION:

It was voted to authorize Mr. Won to spend whatever part of the $40,000 is necessary to maintain the EMS program until he is reimbursed by the release of state funds.

G. MEDICAL EDUCATION: Dr. Bruce reported that she has met with several physicians on the neighbor islands on mandatory CME requirements. Kona Hospital has applied for accreditation. A written report of her meeting in Chicago will be distributed to the Council prior to the next meeting.

H. PUBLIC HEALTH COMMISSION: Dr. Kuboyama reported that mandatory pre-marital screening for Rubella was not passed by the 1978 House of Delegates. He felt that representatives from the Ob-Gyn society, pediatric society and family practitioners and HMA should develop an active immunization program in preparation for the next legislative session.

ACTION:

It was voted to approve the recommendation that HMA become involved in an active rubella immunization program in preparation for the 1979 legislative session.

I. TEL-MED COMMITTEE: Mr. Won reported that the contract with HMSA on the operation of Tel--Med expires in December and it is recommended that the same three year contractual agreement be executed. At present HMA pays for the rent of space for Tel-Med operations and one operator. The Council will vote on extending this agreement next month.

J. 1979 ANNUAL MEETING SITE: It was reported that the HMA Annual Meeting will be held in 1979 in conjunction with the AMA again. AMA will take responsibility for all state of the art lectures and scientific programs. One HMA representative, Dr. Herbert Uemura, will work closely with AMA Council on Continuing Physician Education. The Hawaiian Regent had been suggested as a site for the meeting, however, some feared that the convention site would not be completed in time for the meeting.

ACTION:

It was voted to return to the Ilikai Hotel for the 1979 Annual Meeting.

K. FED SUIT: The Federal Election Commission suit against AMPAC, AMA, state medical associations and their PAC's stemming from the complaint filed by Common Cause that these organizations violated campaign spending limit laws has not made any progress since the Council last met.

L. AUXILIARY GUEST DAY: Mr. Won gave a brief Auxiliary Report for Mrs. Yim noting that the Auxiliary Guest Day will be held at the Ala Moana Hotel, November 28 and the program will be entitled "Teenagers-Their Problems and Promise."

M. HAMPAC BOARD: Dr. Howard announced that Dr. L. Q. Pang had been elected President of the HAMPAC Board for 1979 and Mrs. Alice Tucker was named Secretary/Treasurer.

N. PRE-MED SOCIETY REQUEST FOR CONTRIBUTION: In a letter from the Treasurer of the Pre-Med Society of the University of Hawaii, they stated that they will organize a health fair for November 15 and requested a monetary contribution in support of their project.

ACTION:

It was voted to contribute $100.00 to the Pre-Med Society 1978 Health Fair.

O. PRUDENTIAL SECOND OPINION PROGRAM: Many physicians in the community have received letters from the Prudential Insurance Company asking them to serve on a panel of physicians who would render second opions for their policy holders who are anticipating surgery. Council members pointed out the following: (1) the consulting physician, under the agreement, could not do the surgery even if the patient wishes; (2) we would not encourage a mandatory second opinion program, (3) limits the patients choice of physicians and (4) HMA should oppose this program on the basis that by agreeing in principle, we accept the premise that there is a large amount of unnecessary surgery being done here.

ACTION:

It was voted that HMA oppose the Prudential policy on second opinions and that the HMA Executive Committee should develop a statement to go out to all HMA members on this matter.

P. DSSH MEDICAL ADVISORY COMMITTEE: DSSH sponsors a Medical Advisory Committee under the federal regulations for Medicaid. Three of the 20 members are practicing M.D.'s. Two vacancies are open at present and Mr. Chang requested physician nominees.

ACTION:

It was voted to nominate Dr. Thomas Cahill and Dr. Roy Kuboyama.

Q. NURSE MID-WIFERY PROJECT: North Shore Clinic has applied for renewal of their malpractice insurance coverage through Argonaut Insurance, however, they wish to cover nurse mid-wives in their insurance. Argonaut has requested an opinion on this situation from the HMA.

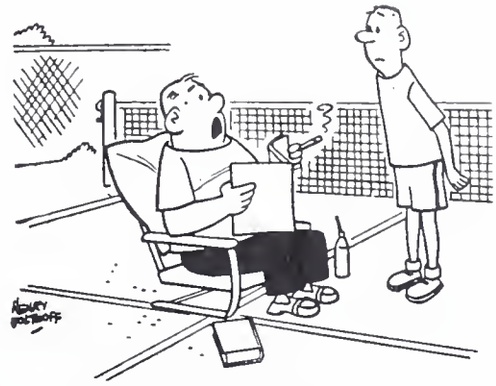
ACTION:

It was voted to refer this matter to the Professional Liability Committee for review and comment.

The Committee will return to the Council with a recommendation on malpractice coverage for nurse mid-wives under a physician's policy.

ADJOURNMENT:
The meeting was adjourned at 10:15 p.m.

NEALWINN
Secretary



"My doctor told me to spend three hours a week on the tennis court."



Clinical Pathologist's Easy Chair

FRANCIS FUKUNAGA, M.D.

Haptoglobin

Haptoglobin is an alpha-2 globulin that has the ability to form stable complexes with hemoglobin. Haptoglobin is synthesized by the liver and normal serum values are approximately 100 to 200 mg/dl expressed as hemoglobin-binding capacity.

Human haptoglobin shows genetic polymorphism. There are two major genotypes and three phenotypes (Hp 1-1, Hp 2-1 and Hp 2-2). The hemoglobin-binding capacity is higher in the Hp 1-1 than the others. The determination of the phenotypes may be of aid in paternity studies.

When hemoglobin is released into the circulation, it immediately combines with haptoglobin and this complex is removed by the reticuloendothelial system. The formation of this haptoglobin-hemoglobin complex helps prevent deposition of hemoglobin or its components in the renal tubules. Serum haptoglobin is rapidly depressed in hemolytic conditions, but may also be depressed with liver impairment. A decrease to less than 30 mg/dl or a fall of 50 to 70% from its original level is highly suggestive of hemolysis. Determination of haptoglobin levels before and after a blood transfusion is a valuable diagnostic tool in suspected hemolytic transfusion reactions. Hemolysis in the donor blood can cause the same effect. In an individual with an average blood volume of five liters, hemolysis of 20 ml of whole blood or 10 ml of packed red blood cells will lower the haptoglobin by about 100 mg/dl (1). Regeneration of the lost haptoglobin requires about 7 to 10 days. The serum haptoglobin level may also be used to differentiate hemolytic from obstructive jaundice.

Haptoglobin is an acute phase protein that responds nonspecifically to various infections such as rheumatic fever, glomerulonephritis and ulcerative colitis, to neoplasia and to other stressful situations such as biliary obstruction and myocardial infarction. The increased haptoglobin in these conditions is reflected in the acute stress pattern demonstrated by serum protein electrophoresis.

REFERENCE

1. Fink DJ, Petz LD, Black MB: Serum haptoglobin, JAMA, 199:615-618, 1967.

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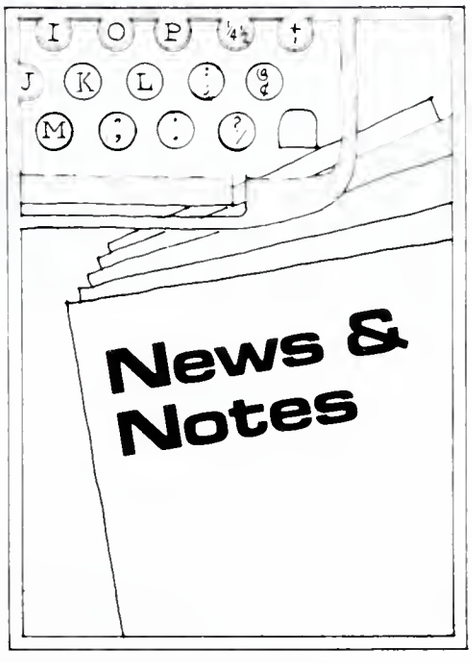
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DERMATOLOGY



HENRY N. YOKOYAMA, M.D.

Professional Moves

As the Year of the Horse comes to a close, we note a definite slowing of the vigorous pace set earlier in the year. In November, the Kaiser Permanente group added internist **Peter Nikaitani** and FP **Daniel Sowinski** . . . The Honolulu Medical Group added internist **Kenneth Hughes** and they have asked cardiologist **Mort Berk** to remain on till June next year . . . Orthopod **Stanley Mun Kong Chung** opened his office at the Kapiolani Children's Medical Center and internist **William Bruce Jr.** joined the Kukui Plaza Medical Associates at 50 So. Beretania St. . . . OB Gyn person **Elenita Alvarez-Pacpaco** opened her office at Suite 314 Professional Center Building.

On the Big Island, internist **Alan "Sammy" De Silva** opened at 319 Kinoole St. and general surgeon **Timothy Oldfather** opened at 670 Ponahawai St. . . . On the Garden Isle, orthopod **Larry Magnussen** joined the Kauai Medical Group Inc. at G.N. Wilcox Memorial Hospital.

An interesting duo, **William Kirker** and **Nabil Rashad** opened three "urgent clinics" simultaneously, viz the Beretania Urgent Clinic at the Beretania Medical Dental Plaza; the University Urgent Clinic at Moiliili Plaza, University Square; and the Waikiki Urgent Clinic at 305 Royal Hawaiian Avenue; all with 24-hour telephone service and office hours 9 am to 5 pm Mon. through Fri. and Sat. 9 am to 12 noon. (Physically impossible, you say? Well, perhaps they can catnap between patients and the 24-hour telephone service and rest all day Sunday . . .)

Quotable Quotes

"Lord, deliver us from the man who never makes a mistake and also from the man who makes the same mistake twice." (William Mayo)

"In our society, we're very anal about research." (**Jack Scaff,** re, prospective vs retrospective studies on marathon running and heart attacks.)

"It was strawberry jam and cream." (Neurosurgeon **Max Urata** describing the spinal cord in a 52-year-old man with cord transection from a fracture dislocation of C5 and C6.)

Life In These Parts

A year ago, Ralph Nader's Health Research Group declared that women had received unnecessary breast cancer treatment and that four of them were from Honolulu. In October, a medical review panel finally admitted that indeed 37 women had needless surgery after being mistakenly diagnosed. **Fred Gilbert,** director of the Pacific Health Research Institute, had said that none of the four underwent radical mastectomies and the Isle pathologists stood behind their diagnoses . . . Fred also noted that the Washington pathologists who alleged the mistaken diagnoses were themselves widely at variance in their findings and conclusions. Fred had said last year that treatment was appropriate for the microscopic abnormalities diagnosed in the Honolulu cases . . . It is not known at this time if any of the 37 announced cases included the Honolulu cases . . .

Abraham Nomura, epidemiologist with the Hawaii Cancer Center and the Japan-Hawaii Cancer Study, announced that mortality data on lung cancer has reached alarming proportions in the past 20 years. This is in line with the National Cancer Institute report released recently which showed an increasing rate across the country and a 8% rise among white women. **Larry Piette,** executive director of the Hawaii Cancer Center, also agreed that lung cancer is increasing in Hawaii and more substantially among women. By ethnic groups, the highest incidence of lung cancer is among Hawaiians, with Caucasians running a close second. Filipinos and Chinese recorded the two lowest rates. Larry reported that breast cancer was also high among women in Hawaii, but lower than the national average with the highest incidence among Caucasians and the lowest among Filipinos. The Japanese, curiously enough, have doubled their rate in the last decade.

"**Bob Flowers,** the plastic surgeon who's been known to have given some women clients T-shirts that said, 'Boobs by Bob' . . ." (Daacon Nov. 16)

Henry Yim, Hawaii Chapter chairman of the American Academy of Pediatrics, announced a statewide program to begin in January 1979 which will focus on the four areas of

accident prevention, health education, immunization and nutrition. Henry says, "Pediatricians in Hawaii and throughout the country believe it is time that all of us recognize the special needs of infants, children and adolescents. We want this State and the country to stop wasting its most valuable natural resource—children."

A study of Hawaiian remains 200 to 300 years old indicates that Islanders had a life expectancy of about 30 years . . . Robert Gardner and Robert Schmitt report that today a baby girl born in the Islands would have a life expectancy of 78 years while a baby boy, 74 years. These values are the highest in the United States and among the highest in the world . . . However, the authors add that there is a trend toward a slowing of the rate of this progress and it may have reached a plateau . . .

Jack Scaff our marathon guru is also a weather predictor. When the weatherman reported "probably sunny" and it rained a storm instead, he wrote, "Why not just go back to the plain old fashioned barometer . . . Mine for example was made in 1780 and yet started dropping 12 hours before the rains hit. So by using this, then comparing with the satellite photos and putting both together, it at least looked like we were in for more than 'probably sunny.' As far as weather forecasting goes, we don't seem to be any better off than we were 200 years ago. The rheumatism in my bones also works just fine. When I have to take more than two aspirin, I know it's going to rain. Try it!"

Elected, Honored & Appointed

Pac PSRO at their recent Annual Meeting in October elected to the Board, **Winfred Lee, William Sage, Peter Kim** and **Winfred Chang** for three year terms . . . The Board elected **Winfred Lee** president, **James Stewart** VP, **Murray Berger** secretary and **Robert Willcox** treasurer.

The Honolulu Medical Group Research and Education Foundation elected **Richard Littenberg** president . . . Installed as three year board of trustees were included the following physicians: **Morton Berk, Vincent Freidwald, Norman Goldstein,** and **Judson McNamara.**

The Hawaii Division of the American Cancer Society elected **Francis Lock DDS** president. Other officers include **Reginald Ho** VP and new board members: **Drake Will, Manas Ghosh, Robert Weiner** and **Henry Hoffman** . . . The American Cancer Society honored QMC chief pathologist **Drake Will** with its National Division Award, the highest national award that can be given a volunteer. Drake served as Hawaii Division president for 3 years and as national professional delegate director from 1973 to 1977 . . .

Cardiologist **Stewart Matsumoto** was elected to fellowship in the American Heart Association Council on Clinical Cardiology and fellow cardiologist **Eugene Magnier** was admitted to fellowship in the American College of Cardiology.

Plastic surgeon **Frank McDowell,** editor of the *Journal of Plastic and Reconstructive Surgery* and a historian who has compiled a five-volume study of the development of plastic surgery from 400 B.C. in India to the present, was honored by the Educational Foundation of the American Society of Plastic and Reconstructive Surgeons . . .

Orthopod **Thomas Grollman** of G.N. Wilcox Memorial Hospital was elected president of the 50-member Hawaii Orthopaedic Association. Honoluluans **Thomas Walinski** was elected VP and **James Oda** secretary.

Ralph Hale, chief of OB-Gyn at Kapiolani-Children's Med Center and chairman of the Dept. at the U.H. School of Medicine was named president-elect of the Pacific Coast Fertility Society at a recent meeting of the 600-member organization in Scottsdale, Ariz.

"Runner's World" magazine nominated cardiologist-jogger **Jack Scaff** for the "Best Scientific Development" award and the "Best Coach for 1978" award. The magazine also nominated The Honolulu Marathon as the "Best Race Organization" . . .

Castle Memorial Hospital re-elected **James Budde** for a second term as president of the medical staff and **Joseph Palma** Vice Chief and **Robert Nemechek** secretary . . .

Embarrassing Moments . . .

"**David Eith** tells the story of taking his baby daughter into the men's room at Disneyland to change her diaper . . . He slipped into a booth with her so as not to attract attention in the busy restroom and tried to stop her squirming by saying, 'Hold still, Jennifer.' There followed a deafening silence in the place and the red-faced doctor beat a hasty retreat with young Jennifer . . ." (From an old clipping dated Jan. 10, '74 . . . Donnelly's Column)

Poetic Justice

"Two doctors were having a drink together at their club. One noticed the other was imbibing rather heavily, asked if anything was wrong . . . 'Last night,' came the dour answer, 'I got the ultimate rejection. I was in church praying for divine help—and a deep, majestic voice answered, 'Take two aspirin and call **Me** in the morning.' " (Submitted by our friend **Frank Kaito,** Deputy City & County Finance Director)

Visiting Professors

Irwin Ziment, associate professor of medicine at UCLA, was here in October for the 122nd Annual Meeting. Irwin feels that "medicine has to get back in touch with people's everyday needs . . . Medicine has become grossly out of touch and expensive . . . People are looking for more natural means of health care—things they can do without going to the doctor" . . . One old remedy that led Doctor William Harvey to discover the circulation of blood was the use of a clove of garlic in one's shoe to treat bronchitis . . . Harvey figured that the pungent odor of the garlic must get through the skin and somehow move through the body to the lungs to be effective . . . It was the 12th century scholar Maimonides who first recommended chicken soup as a remedy for lung diseases—a

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The Management and the Staff, Medical Division, extend to you their appreciation for your support during the past year and look forward to serving you in 1979.

May you enjoy a very Happy Holiday Season and a prosperous New Year.

Lanny K. Williams
President

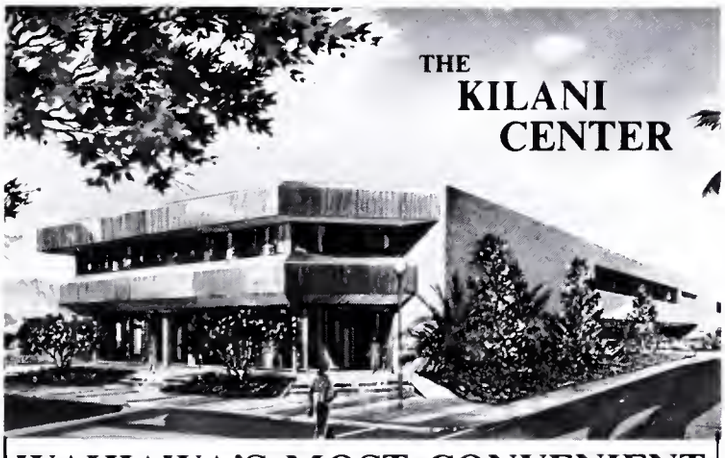
Paul S. Isenburg
Medical Director

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concept only recently confirmed by medical researches . . . In India and China, the people have long used pungent herbs—garlic, ginger, onions, peppers—for the treatment of lung diseases . . . Modern cough medicines often contain compounds that act in the same way as these herbs . . . It also makes sense to suggest to patients that eating hot spicy foods that makes one's eyes and nose run not only will clean out the old sinuses but also contain chemicals that increase the ability to cough up chest secretions, thereby helping bronchitis . . . In those cases of people whose stomachs don't tolerate such spicy foods, 10 to 20 drops of Tabasco or other hot sauce can be dissolved in a glass of water and used for gargle . . . The heat of the sauce will go up the sinuses and down to the lungs to do its beneficial work . . . Another advantage of eating spicy foods is that they make the diner want to drink more water . . . The new drug for asthma—Intal, a preparation that eases the muscle spasm caused by trying to get one's breath during an attack is a substance called Khellin, used centuries ago by the Egyptians for the same purpose . . . A new drug for bronchitis, good for breaking down sputum in the lungs, is called Mucomyst . . . It is made from a derivative of cysteine—a chemical found in hair and feathers—and thus a chemical equivalent of chicken soup . . ." (Ed: Some old home remedies really do have merit.)

Bulletins

Ron Pion, talented, personable and innovative moderator of radio and TV programs (including "Health Conversations," and the "Your Body, Your Mind" series presently being produced for ETV and cablevision), has founded the Media Institute of Medicine, a nonprofit organization which has begun making films and videotapes on health care subjects. The Institute plans a weekend seminar in Kailua and in June a large conference at the Kuilima Hotel for about 200 physicians and others.



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A Federal Trade Commission judge ruled in November that the AMA illegally restrains competition among physicians and causes substantial injury to the public. Judge Ernest Barnes said, "The AMA adopted and enforced a 'code of ethics' that banned physician solicitation of business, severely restricted physician advertising and took other steps that constituted unfair methods of competition. The AMA's practices have the effect of placing a formidable impediment to competition in the delivery of health care services by physicians. That barrier has served to deprive consumers of the free flow of information about the availability of health care services, to deter the offering of innovative forms of health care and to stifle the rise of almost every type of health care delivery that could potentially pose a threat to the income of fee-for-service physicians in private practice. The costs to the public in terms of less expensive or even perhaps, more improved forms of medical services are great." (Ed: Amen!) The decision stunned the AMA and a spokesman said it would appeal the ruling immediately. AMA executive VP James Sammon called Barnes a hired hand of the FTC who implies that the medical profession could not run its own business . . .

Miscellany

The father of a piano-playing daughter was boasting to his guest, "You know, my daughter has taken piano lessons for 12 years! Have you any requests for her?" The daughter was ready at the piano, eager to demonstrate her prowess. The guest looked at her piano book and asked, "How about Pagenine?" She looked surprised, "Gee! I don't know any of his works." The guest pointed to page 9 in her piano book, "See, here it sez Pagenine . . ." (As told by **Walter Loo,** our golfing-appraiser friend)

A pretty young thing was sitting alone in a Hawaiian Village bar . . . A lonely tourist sent her a drink and she accepted graciously. Encouraged, he sat next to her, but before he could strike up a conversation, she suddenly shouted, "Go to your room?" All eyes turned . . . Embarrassed, he whispered, "Excuse me, I just wanted to buy you another drink." She shouted, "Right now?" Again everyone turned to look. He was about to beat a hasty retreat when she explained soto voce, "I'm a college psychology major gathering material for a thesis on human behavior in a bar. If I embarrassed you, I apologize." He yelled in a loud, mortified voice, "What, $150?" (Another **Walter Loo** joke)

Hors De Combat

Tom Nesbitt, AMA President, says a dispute over the right of chiropractors to refer patients to physicians could leave the medical profession in a "dangerous array." Tom feels that to continue the dispute would be tantamount to professional suicide.

The current dispute centers on a recent lawsuit brought by chiropractors in Pennsylvania and the AMA, as part of the settlement, agreed that a doctor may choose to either accept or decline patients sent by a chiropractor. Tom also touched on abortion practices in Chicago: "Physicians have taken the timeless and irrevocable oath that first we must do no harm . . . such as the injury and death that have resulted from unscrupulous solicitation of patients from some abortion mills here in Chicago, as well as from the misleading solicitation of patients for cosmetic surgery in California, Florida and elsewhere."

When the US Navy released statistics that Kahoolawe was bombed 40 weeks last year, **Emmet Aluli,** outspoken Molokai physician representing the Protect Kahoolawe Ohana and long an opponent of military use of the island said, "I really want to blast them. The goal of the Ohana is to stop the bombing." Emmet feels this is still worth doing and still possible and is calling on supporters to get together, regroup and strategize. "I have no faith in the Legislature, none whatsoever," and he terms the current policy memo between the State and Navy "a politically soft compromise."

Sportsmen

We were intrigued by Honolulu Marathon participant Margo St. James' letter to the editor. (Margo, as you probably know, is the head of the San Francisco Prostitutes' Union "Coyote" and is an enthusiastic marathon runner who came here on Jack Scaff's invitation.) "I have observed the illegality of prostitution in the United States and the effect it has had on women's lives, for the last five years . . . bad! It makes sex (for women) a crime and therefore a weapon in the hands of men who wish to do women harm . . . Denmark decriminalized prostitution in 1958, per the United Nations' recommendation of Dec. 2, 1949, and sexual assault crimes against women dropped by 70 per cent in one year. The converse happened in Australia in 1965 when the country criminalized prostitution—rape went up 149% in one year . . . The advent of prostitution as a legitimate occupation dignifies the sex act and people participating have legal recourse to exploitation, abuse and other crimes committed against them like other citizens . . . Thus the criminalization of sexual acts between consenting adults is a very counterproductive law promoting the rapist attitude in our society. Although rape is certainly an act of hate, not love or lust and has nothing to do with the availability of sexual partners, the legalization of prostitution does diminish sexual assault crimes against women and children. Therefore I advocate the total decriminalization of what is nauseatingly called the "world's oldest profession" and I would hope the women's movement would make it a priority issue as soon as possible." Margo St. James . . .

Jack Scaff Says

"Physical education in the public schools is dropping . . . We go to sports games now to watch someone else play; this is now our exercise . . . We like to think of ourselves as an athletic nation with all our interest in sports, yet our individual life-style doesn't support this belief . . . The lack of physical activity has made man an endangered species in the US . . . One out of two males will die of cardiovascular problems . . . People who smoke worry about cancer, but the statistics indicate they will probably die of heart attack first . . . Life insurance companies have risk tables showing that from 30 years on, the most common cause of male death is a heart attack . . . Now it's true that women have a better chance of warding off heart problems, but when you get older, it's no fun being a widow . . . It's not so much the marathon itself that improves your chances, but the training forces you to adapt a life-style that will eliminate heart worry . . . A program of steady exercise can reduce body fat and cholesterol, the forerunners of heart problems . . . HDL Cholesterol is a substance secreted by your body to combat normal cholesterol build-up . . . It is the transport mechanism that whisks cholesterol through your body and prevents it from settling . . . With prolonged exercise, your body secretes more of this transport mechanism, flushing cholesterol from foods. Marathon training is the ideal exercise because in addition to its tendency to prevent settling of cholesterol, long-distance running can eat away at existing body fat . . . The first 20 to 30 minutes of running, the body fuels off carbohydrates from food intake . . . There is then a switch to a primitive body fueling system that eats away at your fat . . . When your body first begins to switch to this primitive system, you feel terrible . . . But as you begin to run regularly, the transfer from carbohydrate to fat metabolism is not as harsh . . . It becomes an inexhaustible fuel source . . . Ancient hunter, be it man or animal, used this fueling system which kept him free of today's health problems . . . The marathon becomes a harmless practice of converting to this fueling system in an attempt to recreate the health lifestyle of yesteryear's man . . . All types of hunting animals are programmed to practice this survival activity, even if it is in their play habits . . . Take the hunting animal and put him in an inactive environment such as the zoo and he dies of a degenerative disease . . . Man's environment has become a type of zoo . . . Medieval hunting practices or the marathon is our answer . . . *My goal is immortality or old age, whichever comes first.*"

Community News

Tom and **Henrietta Fujiwara** were guest exhibitors of their pathiopedium collection at the annual Club 100 Green Thumbs Orchid Show Plant Sale held in November at the Club 100 Memorial Building . . . "And speaking of big bands, Connie Kissinger and Steve Dulce will be headlining the show at the Hawaii International Country Club Wednesday, a benefit for **Dr. George Takushi's** band, the Torchers . . ." (From Donnelly's Hawaii Nov. 19) . . . "And the Beat goes on: First it was Del Courtney's orchestra for tea dances at the Royal—now it's Dr. George Takushi's 16-piece band, The Torchers!, playing cheek-to-cheek music at the Point After. G.M. Lee Afuvai, who'd eventually like to open a proper ballroom, admits the band is a nice change from constant disco and plans to have the group there every Tuesday . . . Takushi, by the way, no longer has trouble finding a place to rehearse—he's just built a sound room on his Portlock property . . . (Daacon Dec. 7) . . . And **Dr. E. Gordon Dickie** is back from Canada where he finished his latest book, a novel about Aspen, Colo. (Donnelly's Hawaii Sep. 6)

In the past 10 years, the team of **Robert Flowers, John Edwards** and **Edwin Gramlich** have performed between 20 and 50 sex change operations to transform genetic men into anatomical females. The team reported on the subject at the Nurses Association of the American College of Ob and Gyn at the Hyatt Regency Hotel. Bob said, "The real test of success is when they can fool a gynecologist. They have reported comments such as 'You must have had your hysterectomy from below,' when the doctor discovers that they have no cervix." The most gratifying thing to the team members has been the improvement in the quality of life for patients on whom they have performed the operation.

This year's QMC Festival of Trees is targeting at the pur-



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chase of the Mevatron XX, a high energy linear accelerator for cancer treatment. The Mevatron XX is being built by Siemons Corporation in California and produces high energy photons of 15 million volts.

Hawaii's hospitals are slowing the pace of their rate increases, but rates for the first half of 1978 still were up 13 percent from last year. **George Mills,** chairman of the Voluntary Cost Containment Committee, announced the rate figures. This is more than twice the price increase target announced by President Carter, but island hospitals say there is no way they can meet the presidential goal of limiting all price increases to 6.5 per cent in 1979 . . .

The asbestos control program put into effect at Pearl Harbor earlier this year is identical to one that was required by law in 1972, yet never implemented . . . The monitoring program was recently extended to all 6,200 shipyard employees, recognizing that all face asbestos exposure. To date, reports on 1,306 workers have been processed and 176 have indications on X-rays of asbestos exposure.

Conference Notes

(Desultory notes from **Irwin Schatz's** QMC lecture entitled "The Myths and Realities of Antiplatelet Therapy in Vascular Disease")

Recent revival of the role of platelets in atherosclerosis . . . Austrian pathologist Rokitansky had suggested long ago that thrombi causes atherosclerosis . . . But the enthusiasts of the filtration theory pushed the thromboatherosclerosis theory into the back seat . . . The thromboatherosclerosis theory postulates that atherosclerosis is secondary to activation of platelets which form the nidus of thrombi . . .

I. *Theories of Platelet Function:* A. Biologic properties: 1. Hemostasis 2. Thrombosis of: large arteries and microcirculation; heart valves and chambers; prosthetic surfaces; veins? . . . B. Other properties: 1. Atherosclerosis (mitogenic factor) 2. Vasospasm (thromboxane A_2) . . .

II. *Platelet Reaction:* A. Aggregation caused by: 1. ADP (tissue injury); epinephrine (? stress); thrombi (coagulation) 2. Thromboxane A_2 synthesized from prostaglandins 3. Platelet ADP . . . B. Adhesion: aggregated platelets change shape and adhere . . . C. Release Reaction: Platelets adhere, aggregate and release ADP . . . D. Inhibitors-Activators: Dynamic process . . . Prostacyclin produced by vessel walls become precursor of prostaglandins . . .

III. *Phenomenon of Platelet Shape Change:* Round forms become dendritic and then become spread forms . . . In post MI patients, 50% of the platelets are spread forms up to 18 months . . . In IHD (ischemic heart disease), 41% are spread forms . . . Plasma from IHD patients induce spread forms . . . Phenomena not restricted to IHD and MI patients but in other conditions eg in chronically ill . . . *"There is overwhelming evidence suggesting platelets play an important role in atherosclerosis . . . The question is should we use antiplatelet factors? My own answer is a qualified 'Yes'."*

IV. *Antiplatelet Factors:* A. ASA: Inhibits PL aggregation and release reaction by preventing synthesis of prostaglandins and thromboxane A_2 . . . High concentration of thrombi and collagen can overcome ASA effect and induce release reaction . . . Average dose (0.3 to 1.2 gm) . . . Affects PL for 4-7 days . . . B. Persantine: Introduced as coronary vasodilator in 1961 . . . Increases PL cyclic AMP level and lowers prostaglandin level . . . Low dose ASA potentiates persantine . . . C. Anturane: Uricosuric agent . . . May be competitive inhibitor to PL prostaglandin synthesis and lowers release reaction . . . Plasma half life 2 hours . . . D. Propranolol: PL aggregation by epinephrine is mediated through Alpha receptors; so it is not known how propranolol inhibits PL aggregation . . . E. Dextran: Only in post op situation . . . Use in 500 to 1000 cc 5% Dextran solution . . . F. Heparin: Inhibits PL reaction . . .

V. *Rationale for Antiplatelet Drugs in IHD:* a. Prevents PL fibrin thrombus in major epicardial vessels b. Prevents microemboli formation and consequent occlusion of microcirculation c. Prevents PL-released thromboxane A_2 which causes coronary spasm . . .

VI. *Survey Studies:*

1. Boston Drug Surveillance: Conclusion that ASA prevents MI
2. Elwood etal: 300mg ASA to post-MI patients resulted in increased survival
3. Anturane Studies: 200mg qid involving 1475 post-MI patients for 8.4 months . . .
 Death rate: 5.1% with Anturane vs 9.5% with placebo

	Anturane	*Placebo*
Cardiac deaths	24	44
Sudden deaths	23	29
MI	9	12
Annual death rate	4.9	9.1
Annual sudden deaths	2.7	6.9

VII. *Present Status*

1. Administering ASA to IHD is empirical, but not unreasonable
2. Short term value of Anturane in recent MI pts is established (weeks to 8 mos), but long term effects are unknown . . .
3. Whether or not Persantine will potentiate clinical usefulness of ASA is unknown . . .

VIII. *Cerebrovascular Disease:* Fields etal . . . 187 pts with carotid TIA's . . . ASA (4 tabs/d) showed significant decrease in TIA's . . .

Tayler (NEJM 7-78) 585 TIA's treated with ASA, Anturane, and ASA plus Anturane: Results: TIA's, strokes, and deaths decreased with ASA, but not with Anturane . . . Best group: older hypertensive patients with multiple past episodes of TIA's . . .

IX. *Prosthetic Devices:*

1. PL survival decreased: ASA 1 gm/d with Persantine 400mg/d increase PL survival . . .
2. Reasonable regimen: Coumadin with above regimen

X. *Venous Thrombosis and Retinal A Occlusion:* Use heparin and oral anti-thrombic drugs . . . No known antiplatelet drugs found to be effective . . .

Miscellany

"You know what the latest Polish joke is, don't you?" Ans: "The Pope . . ." (Heard by **Irene Wong** on the Aku program)

The first thing the Polish Pope did was to make a blind man walk . . . (As told by **Bernard Fong**)

"Do you know why all the Hawaiian kids in school aspire to become astronauts?" "Because they've been told they take up space." (Another **Irene Wong** contribution)

The inventor of the flush toilet was a Thomas Crapper. (According to **James Nishi**)

Conference Notes

VIRAL HEPATITIS (Extracted from **Gary Glober's** Friday morning QMC lecture):

General Discussion: *Hepatitis B*—Core of Hepatitis B virus replicates within hepatocyte nucleus, migrates to cytoplasm, is coated and becomes a 42 nm Dane particle . . . Dane particles are found in liver cytoplasm and esp. in serum. Hepatitis B Surface Antigen (HBsAg) cling to surface of Dane particle and disappear with recovery from hepatitis . . . Antibody (AntiHBs) appear later . . . Antigen (HBcAg) found in core of virus with its antibody (Anti-HBc) . . . AntiHBc is sensitive indicator of infectivity even without detectable HBsAg . . . The "e" antigen HBeAg is present in long term HBsAg carriers . . . eg. chronic hepatitis (55%), cirrhosis (31%), in acute hepatitis (10%) . . . HBeAg is also sign of infectivity along with Dane particle, Anti-HBcAg and DNA polymerase . . . Donors with anti-HBe (even if positive HBsAg) do not transmit post-transfusion hepatitis . . . Positive HBeAg mothers

transmit hepatitis to offspring . . . Also genetic subtypes of HBsAg: Sub-type D, Sub-type Y and Sub-type W . . .

Hepatitis A: 27 nm particle in stool of acute phase patients . . . HAsAg is transient . . . Hepatitis A resolves in 4 weeks, whereas drug hepatitis resolves in 2 weeks after stopping drug . . .

Non-A/Non-B Hepatitis: Incubation period 20 d to 6 mos. and negative for hepatitis A and B . . .

Transmission of Hepatitis B: Blood via transfusions, needles, tatoos, etc.; also aerosols; mosquitos; bedbugs/cockroaches; urine; saliva; bile; semen; breast milk; tears; vaginal secretions; sweat; cerebral spinal fluid; clams; also sexual transmission . . .

Hepatitis B Viability: Viable 1 year at room temp.; destroyed by autoclaving at 121° C for 15 min.; boiling for 20 minutes; and dry heat 170° C for 60 min.

FEATURES:

	Hepatitis A	**Hepatitis B**
Previous terms	Infectious MS-1	Serum MS-2
Principle Age	Children	Adolescents
Routes	Fecal-oral	Parental Oral
Incubation		
Average	3-5 wks	6-20 wks
Extremes	2-16 wks	4-30 wks
Clinical		
Fever 38° C	Common	Less common
Anorexia	Moderate-extreme	Mild-moderate
Nausea, vomiting	Common	Less common
Rash	Rare	Common
Arthralgia/arthritis	Rare	Common
Glomerulonephritis	Unknown	Reported
Chronic Liver Dis	Rare	10%
Icteric Phase		
Children (6-15)	10 d	19 d
Adults (56-70)	22 d	46 d
Duration of Transaminase Elevation	1-3 wks	1-6 mos
Immunity		
SIG (Standard Immune Globulin)	Regularly preventive	Possibly prevents or ameliorates
HBIG (Hepatitis B Immune Globulin)	———	Prevents

CLINICAL:

Anicteric hepatitis: most frequent esp. in younger person . . . In Taiwan: anicteric ÷ icteric ratio 34:1; in US estimated 2-12:1

Pre-icteric stage: flu-like; icteric stage: fever and other sy's . . .

Extra-hepatic Complications: pneumonia, myocarditis, arthralgias, agranulocytosis, glomerulonephritis, polyarteritis nodosa, cryoglobulinemia, pancreatitis, lipid storage myopathy, etc. . . .

Lab Notes:

a. Acute viral hepatitis: SGPT higher than SGOT; acute alcoholic hepatitis: SGOT higher than SGPT.
b. High iron levels may be due to antigenemia and not liver damage . . .
c. IgM rises in Type A Hepatitis and Icteric Type B hepatitis, but not in drug hepatitis . . .

TREATMENT OF ACUTE HEPATITIS:

a. Rest: Bed rest not necessary in patients below age 40 unless no improvement or relapse.
b. Diet: No restrictions unless complications . . .
c. Steroids: No proven value; may be harmful . . .
d. Alcohol: Not really studies . . .

Hepatic Sequelae of Viral Hepatitis:

a. **Massive Hepatic Necrosis** (Fulminant Hepatitis) 0.2-1% Equal risk from Types A or B . . . Rapid progression to coma and death within 10 days. 34% under age 15 survive and 15% over age 15 . . . No response to Hepatitis B immune globulin Rx . . . Liver heals completely if patient survives . . .

b. **Post Necrotic Cirrhosis** (Macronodular Cirrhosis) Disruption of lobular architecture with loss of central veins; extensive fibrosis . . . Rare after Hepatitis A . . .

c. **Chronic Active Hepatitis** (Chronic Active Liver Disease) 3% Related to HLA types A and B8 . . . Can progress to cirrhosis with death within 5 years in 35-50% of cases . . . Secondary to Hepatitis B (perhaps non-A, non-B); drugs (oxyphenisatin, Aldomet, INH, acetaminophen and salicylates, alcohol); etc. Treat with prednisone plus Azothioprine for 2 years or continue until transaminase and gamma globulin values are normal . . . No evidence that Hepatitis A causes . . . Transfer factor and Levamisole not useful . . . Intereron reduces HBsAg, HBeAg and viral DNA transiently . . .

d. **Chronic (Benign) Persistent Hepatitis:** 5-10% Good prognosis . . . Wait 6 months after onset of abnormal liver function tests to biopsy . . . Will resolve without Rx . . .

IMMUNITY NOTES:

Since 1944, SIG levels of AntiHBs have increased.

HBIG protected against hepatitis more than SIG at 6, but not at 9 months. In another study, HBIG was more effective at 6 and 9 months . . .

Present recommendations: Give HBIG 5 cc no later than 7 days after Hepatitis B exposure and another 5 cc 30 days later . . . HBIG also effective in newborns of mothers with positive HBsAg.

SIG for protection against Hepatitis A:

Exposure	**Pounds**	**Dose in ml**
Household, institution	Under 50	0.5
Short-term travel (under 3 months)	50-100	1.0
	Over 100	2.0
Long-term travel (over 3 months)	50-100	2.5
	Over 100	3.0

Administer every 6 months as long as risk persists . . .

Who's Boss?

When the body was first made, all the parts wanted to be boss.

The brain said, "Since I control everything and do all the planning, I should be boss."

The feet said, "Since I must carry man everywhere he wants to go, to get him in position, to do what the brain wants, I should be boss."

The hands said, "Since I must earn all the money and do all the work to keep the rest of you going, I should be boss."

The eyes said, "Since I must look out for all of you and tell you where danger is, I should be boss."

And so it went until the heart, lungs and finally the anus spoke up and demanded that he be made boss.

All the other parts laughed and laughed at the idea of the anus being boss.

The anus was so angry that he blocked up and refused to function. So the brain was feverish, the eyes were crossed, the hands hung limply at the sides, the heart and lungs struggled to keep going. All pleaded with the brain to relent and let the anus be boss, and so it happened.

All the other parts did all the work and the anus just bossed and passed out the crap . . .

MORAL: You don't have to be a brain to be boss, just an ———— .

(Submitted by **Tom Leinweber**)

Personalities

"SCAFF Evangelical Cardiologist" (quotes from Grady Timmons' article in Honolulu Magazine, Dec. '77):

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"Jack exaggerates," says James "Willie" Williamson, VP of Aloha Airlines and this year's director for the marathon . . .

"Boy, does he exaggerate," says Scaff's 27-year-old Hawaiian-Chinese wife, Donna, a nurse . . .

"Jack's just great PR," says **John Wagner,** Scaff's sidekick cardiologist. "You take whatever he says, divide by two and subtract six to get the truth." We call it the Scaff Factor . . .

"Consider also that the business of an evangelist is saving souls. What is Scaff doing? He is saving hearts using soles." (Timmons)

"Jack Scaff is preaching that the Kingdom of Heaven is at hand—right here in Kapiolani Park" (George Akita, professor of Asian History at U of H).

"As a child, Scaff was always overweight and in college, friends called him 'Blimp' (at 5'10" he was in excess of 203 pounds)."

"The thing about exercise is that you can't have a prospective study. You can't take a person and make them exercise for 20 years and control all the variables. If a group of people start running marathons and they don't die of heart attacks, you can say that's valid . . . Until they start dying of heart attacks . . . And they haven't."

"Jack says you can eat and drink anything . . . He starts listing pizzas and some of the most dreadful things in the world. The last time he gave the talk, I was sitting in the back with a group of dieticians and I thought they were all going to retch." (Williamson)

"Jack's no charlatan . . . He believes totally in what he's doing. But I swear, if Jack Scaff had been born 50 years sooner, he would have been a medicine man." (An admiring local doctor)

"To those chiding souls who say he looks to be walking when he runs—'piddly little steps, absolutely no stride'—and that his marathon times are always an unspectacular 3 hours and 20 minutes, Scaff rejoins that he finishes more races and is never injured . . . 'I'm indestructible,' he says."

"Jack detests smoking and dismisses diet as another excuse to avoid exercise. True to form, he does not smoke and is a self-confessed glutton. 'There's no question about it. I can eat and drink continuously—forever.' "

"Six years ago, what I'm saying wasn't accepted at all. Now it's accepted begrudgingly."

"Anyone who isn't a runner, isn't worth knowing." (Jack supposedly once said)

"His famous treatment is that if you're not feeling well, take three aspirins and a treadmill." (Says Williamson)

"I'm a heretic. I'm for exercise and America's for rest."

"Today, you're going to learn about what I call PTA—pain, torture and agony!"

"You have to understand that there are only two reasons for running the Marathon . . . The No. I reason is to beat Jack Scaff. No. 2 is to finish. Accordingly you can either be B.S. or A.S. B.S. being Before Scaff, A.S., After Scaff. It doesn't matter what time you do, as long as you beat the old devil." (Williamson)

"Jack, of course, accepts his rising fame with characteristic aplomb. 'I think the next phase is to spend the rest of my life lecturing,' he says, 'traveling the world to the accolades of the saved . . . but, ah well, that might not transpire!' "

Letters *continued from 355*

I think the JAR approved the CON—or at least recommended that the SAC refer it to the next layer in the multi-tiered morass. I hope the doctors can move before their present lease expires, but the outlook is uncertain, depending on the SAC, or the HSHCC, if not the SHPDA. (And to think that we are *paying* for all this foolishness!)

The only Federal bureau the physicians should have had to fool with, of course, was the Post Office. I asked why they didn't just move, and ignore the clowns; they considered it, they told me, until threatened with a fine of $500 per day. Think of it!

But the worst is yet to come: There's talk of expanding this whole circus to review all physician relocations and major office expenditures. The philosophy seems to be that if the Bureau can spend a dollar to save a nickel, and keep a lot of nice folks busy meeting and stapling, it's a worthwhile enterprise.

Heaven Help Us!
JOHN M. CORBOY, M.D.

Our "Angels"

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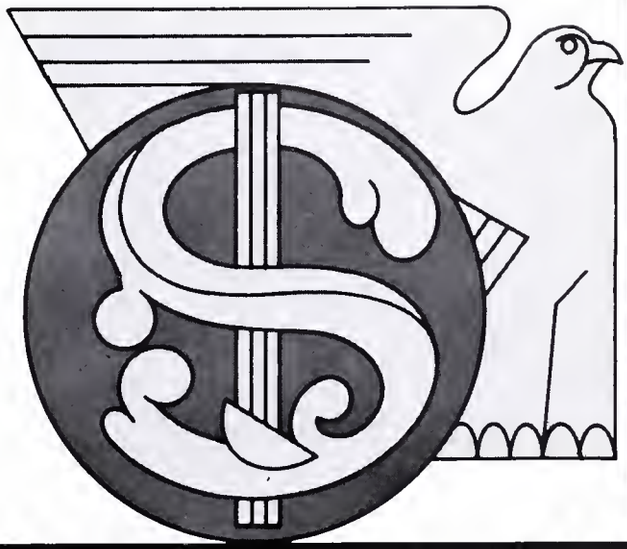
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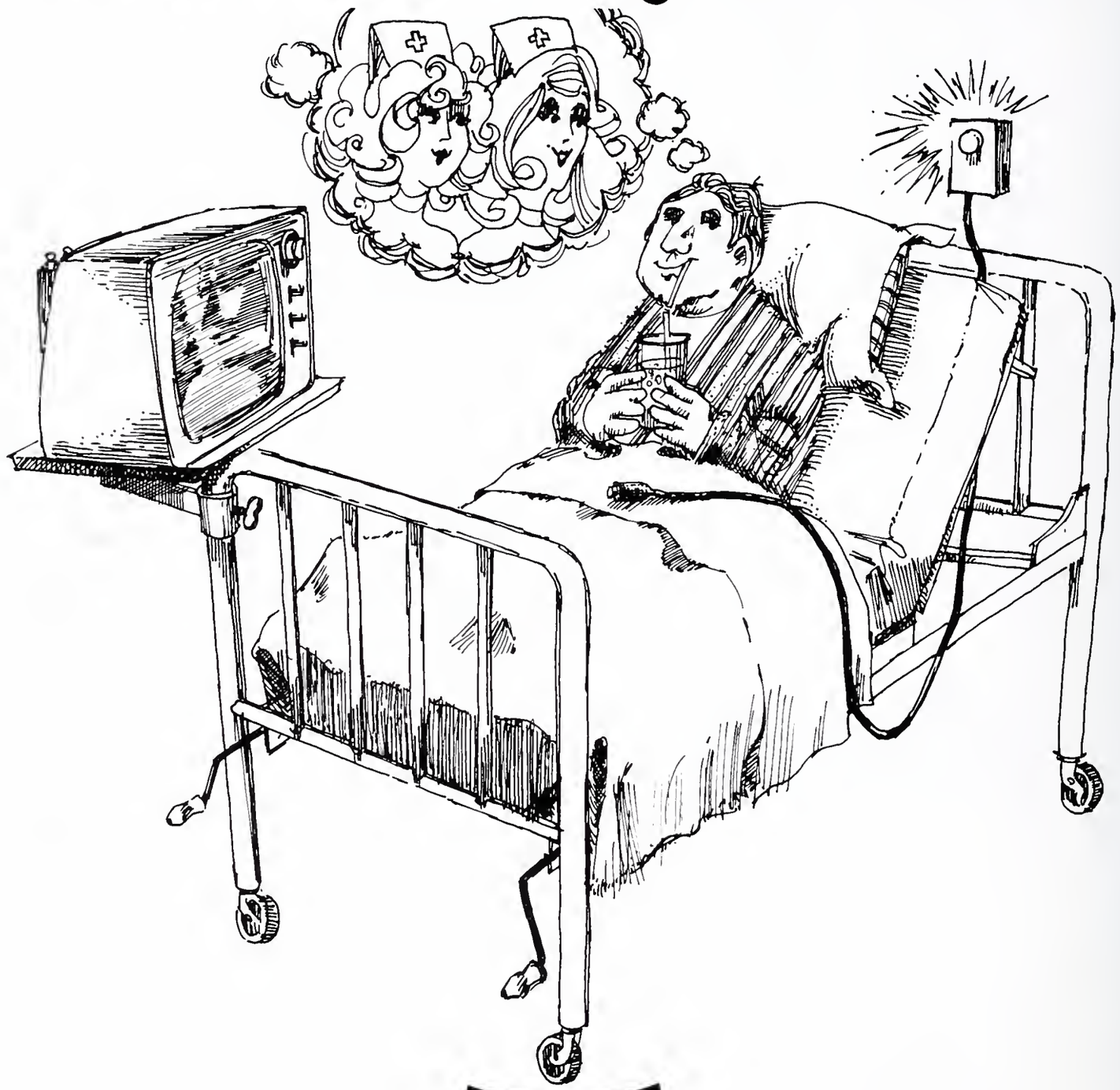
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